

CERTIFICATE OF DEATH

08752

08743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>P. George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Ta. Geo.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BELTSVILLE</i> X0			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PAINT BRANCH H. HOME</i>				d. STREET ADDRESS <i>4814 - MONTGOMERY</i>			
3. NAME OF DECEASED (Type or print) <i>MARGARET F ALBERTIE</i>				4. DATE OF DEATH <i>AUG. 17, 1957</i> 19			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 1875</i>	9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Medical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Amos W. Dutton</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Howell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>511-111111</i>		17. INFORMANT <i>W.B. Albertie</i> Address <i>511-111111</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial failure</i> DUE TO (b) <i>Arteriosclerotic coronary artery disease</i> DUE TO (c) <i>disease</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 1</i> , 19 <i>55</i> , to <i>Aug 17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Aug 17</i> , 19 <i>57</i> , and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Arnold Mc Mitt</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>Aug 17, 1957</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>8-20-57</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematorium</i>		22d. LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Lee Funeral Home - Wash. D.C.</i>				24a. REC'D BY REGISTRAR DATE <i>AUG 19 1957</i>		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG219 8-19-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 15 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6800 Riverdale Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6800 Riverdale Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH ELIZABETH ALSOP		4. DATE OF DEATH Month August Day 12 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1883
9. AGE (In years (birthday)) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Parker		14. MOTHER'S MAIDEN NAME Elizabeth Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alice I. Lawhorn		Address Same as # 2 (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr John T. Maloney		DATE SIGNED Aug 13, 1957-	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/15/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor Pr. Geo. Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR AUG 15 1957		24b. REGISTRAR'S SIGNATURE James [Signature]	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Riverdale	
Age		35 yrs.	
Sex		Male	
Race		Caucasian	
Date of Death		August 12, 1957	
Place of Death		6800 Riverdale Road	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	

BUREAU V. S.

AUG 15 1957

RECEIVED

08745

CERTIFICATE OF DEATH

08754

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MONTGOMERY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY PRINCE GEORGE MONTGOMERY COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		c. LENGTH OF STAY IN b 1 Year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8223 14th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH First Middle Last APPERTI		4. DATE OF DEATH Aug. Month Day Year 10 19 57	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1912
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEF		10b. KIND OF BUSINESS OR INDUSTRY BAKERY	11. BIRTHPLACE (State or foreign country) NAPLES, ITALY
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME THOMAS Apperti	
14. MOTHER'S MAIDEN NAME Theresa Penarolla		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 578-07-9394		17. INFORMANT Thomas L. Apperti Address 303 ETHEN ALLEN AVE. TAKOMA PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Arteriosclerosis (c) 1 Year			INTERVAL BETWEEN ONSET AND DEATH 2 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 1956 to Aug. 10, 1957 that I last saw the deceased alive on Aug. 10, 1957 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Laubach M.D.		ADDRESS (Street, city or town, state) 1806 FOX ST, Hyattsville, Md. DATE SIGNED 8/10/57	
PHYSICIAN'S NAME (Type) James L. Laubach, M.D.		1806 Fox St., Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/13/57	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		24a. REC'D BY REGISTRAR DATE Aug. 13 1957	24b. REGISTRAR'S SIGNATURE Mrs. Jas. Savarese Deputy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08755

Reg. Dist. No.

234

08808

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River				d. STREET ADDRESS R.F.D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marvin Dale Arrington				4. DATE OF DEATH Month Day Year August 22 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1935	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Sand dredging		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles E. Arrington	
14. MOTHER'S MAIDEN NAME Myrtel Kelley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Myrtle Arrington, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from barge into river			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1:30:00 8/22/ 57		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Oxon Hill P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>James I. Boyd</i>				DATE SIGNED August 22, 1957			
EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/57		22c. NAME OF CEMETERY OR CREMATORY Cranford Memorial		22d. LOCATION (City, town, or county) (State) Fairfax County Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR AUG 29 1957		24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the coroner. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
James E. Harrison		45		Male		White		August 28, 1957		Baltimore, Maryland	
Residence		Occupation		Cause of Death		Manner of Death		Medical History		Remarks	
1234 North Avenue		Teacher		Heart Disease		Natural		Hypertension, Atherosclerosis		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 AUG 29 1957
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08756

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glassmanor		c. LENGTH OF STAY in 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 - Roseld Court		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glassmanor X2 d. STREET ADDRESS 308 Roseld Court 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard Jeremiah Balacek		4. DATE OF DEATH August 16 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1919
9. AGE (in years, months, days) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Weights and measures D.C. Government	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeremiah Balacek		14. MOTHER'S MAIDEN NAME Marie Salek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 008-03-5174	
17. INFORMANT Emily Balacek		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary atherosclerosis (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 8-16-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl		22d. LOCATION (City, town, or county) (State) 2X Hyattsville Va	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		ADDRESS 1381-1108 Wash, D.C.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE AUG 19 '57	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

BUREAU V. 3

AUG 19 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08746

CERTIFICATE OF DEATH

08757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>P.G.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hyattsville Rest Home</i>		d. STREET ADDRESS <i>15004 - Edmonston Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Sylvia</i> Middle <i>Elizabeth</i> Last <i>Bartoo</i>		4. DATE OF DEATH Month <i>8</i> Day <i>6</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 25, 1866</i>
9. AGE (In years last birthday) <i>90</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Bush</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Cox</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Bernard A. Bartoo (Son)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Hypertension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>33 1/2</i> years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-6-</i> , 19 <i>57</i> , to <i>8-6-</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>July 16</i> , 19 <i>57</i> , and that death occurred at <i>5-17</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arnold A. Lear</i>		M.D. <i>905 Sheridan St</i>	
PHYSICIAN'S NAME (Type) <i>ARNOLD A. LEAR</i>		ADDRESS (Street, city or town, state) <i>Hyattsville, Md</i>	
DATE SIGNED <i>8-6-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/9/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>AUG 8 1957</i>		24b. REGISTRAR'S SIGNATURE <i>James Leveaux</i>	

BUREAU V.

AUG 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08810

CERTIFICATE OF DEATH

08758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1333 Park Rd., N.W., #313	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle H. Last Braxton		4. DATE OF DEATH Month 8 Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/17/10
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Chambers Valet Shop	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Braxton		14. MOTHER'S MAIDEN NAME Rosetta McAllister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.,	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/31, 1957, to 8/11, 1957, that I last saw the deceased alive on 8/11, 1957, and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		M.D. Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8/12/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros.		ADDRESS 621 Flor Ave	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 14 '57			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08753

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
c. LENGTH OF STAY IN 1b D.O.A.				d. STREET ADDRESS 713 Maple Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jane Middle Ann Last Brooks				4. DATE OF DEATH Month Aug. Day 13 Year 1957			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 13 Days 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Chittanis				14. MOTHER'S MAIDEN NAME Nancy Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Brooks; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY Church of the Ascension	
22d. LOCATION (City, town, or county) Bowie, Maryland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John T. Maloney, M.D.				23b. ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR Aug 19 '57	
23c. DATE Aug 13, 1957				24b. REGISTRAR'S SIGNATURE Paul Smith		24c. DATE Aug 13, 1957	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

John T. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

August 13, 1957

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BUREAU V. 3

MAY 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08754

CERTIFICATE OF DEATH

08760

Reg. Dist. No. 242

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Md				d. STREET ADDRESS Hill Road + Central Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Arthur L. Brown				4. DATE OF DEATH Aug 15 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 17 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Richard F. Brown				14. MOTHER'S MAIDEN NAME Lucille			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Addie Brown - same				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x central Hemorrhage DUE TO (b) Arterio-sclerotic cardio-vascular Disease DUE TO (c) Vascular Renal Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 days 10 years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1 1950 to August 15 1957, that I last saw the deceased alive on Aug 15 1957, and that death occurred at 3:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William Brainin M.D. 6124 Central Ave NW 57 PHYSICIAN'S NAME (Type) WILLIAM BRAININ Capital Heights Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-17-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE 8-16-56		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

CERTIFICATE OF DEATH

REG. NO. 11

1. NAME OF DECEASED <i>William Brainin</i>		2. SEX <i>Male</i>		3. AGE <i>25</i>	
4. DATE OF DEATH <i>Aug 12 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Brain tumor</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Poland</i>	
10. OCCUPATION <i>None</i>		11. MARITAL STATUS <i>Single</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>Brain tumor</i>		15. DATE OF ONSET <i>Aug 12 1957</i>	
16. PHYSICIAN'S SIGNATURE <i>Dr. [Signature]</i>		17. COUNTY <i>Harford</i>		18. CITY <i>Bellevue</i>	

19. NAME OF PHYSICIAN <i>Dr. [Signature]</i>		20. NAME OF HOSPITAL <i>None</i>	
21. NAME OF FUNERAL HOME <i>None</i>		22. NAME OF BURIAL PLACE <i>None</i>	
23. NAME OF NEXT OF KIN <i>None</i>		24. NAME OF WITNESS <i>None</i>	
25. NAME OF REGISTRAR <i>None</i>		26. NAME OF CLERK <i>None</i>	

BUREAU V. 3

AUG 19 1957

RECEIVED

William Brainin

BRAININ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2.7 Film 220 9-11-57 et

CERTIFICATE OF DEATH

08761

08811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Upper Marlboro</u> d. STREET ADDRESS <u>Rt. # 2, Box 155 Chew Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bessie E. Brown</u>				4. DATE OF DEATH <u>August 31, 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 2, 1879</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME <u>Flora Quander</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>***</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>****</u>		17. INFORMANT <u>Samuel Brown</u> Address <u>Chew Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerosis</u> <u>260X</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>For three years</u> , 19____, that I last saw the deceased alive on <u>August 28, 1957</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth G Brown</u> M.D. <u>3560 - 13th St. NW.</u> ADDRESS (Street, city or town, state) <u>DATE SIGNED</u>				PHYSICIAN'S NAME (Type) <u>Dr. Kenneth G. Brown, 3560 13th St., N.W. Washington, D.C. 9/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-57</u>		22c. NAME OF CEMETERY <u>St. Mary's Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. ...</u>				24a. REC'D BY REGISTRAR <u>SEP 4 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Quander</u>	

08755

CERTIFICATE OF DEATH

08762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges E				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 14601 Harvard Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Olive Simons Burrus				4. DATE OF DEATH Month Day Year August 24 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-26-95	
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
13. FATHER'S NAME Richard B. Simons				14. MOTHER'S MAIDEN NAME Anna Gilpin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes: no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. None			
17. INFORMANT Russell L. Burrus				Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA OF OVARIES DUE TO 4 yrs (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from June 1953 to Aug 24 1957 , that I last saw the deceased alive on Aug 24 1957 , and that death occurred at 6:00P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry St. DATE SIGNED 8/24/57 ACTUAL SIGNATURE Norman D. Comeau M.D. PHYSICIAN'S NAME (Type) Dr. Norman Comeau My T. Rainier M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/57		22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		22d. LOCATION (City, town, or county) (State) South Sterling Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 27 57	
24b. REGISTRAR'S SIGNATURE W. T. Rainier							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 27 1957

BUREAU V. 21

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08763 *n/s*

08750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN 1b 14 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt Rainier Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4607 25th Street,.			d. STREET ADDRESS 1 4607 25th St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Viola Middle Fannie Last Carson			4. DATE OF DEATH Month August 30, Day 19 Year 57.		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1886	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Frank Dameron			12. CITIZEN OF WHAT COUNTRY? U S A		
14. MOTHER'S MAIDEN NAME Laura Cookman			17. INFORMANT Dorothy V Davis Address Mt. Rainier Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 3 Mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. 9. Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12P	
20f. (City or town) 12P		20g. (County) 12P		20h. (State) 12P	
21. I certify that I attended the deceased from 5-18-57 , 19____, to 8-30-57 , 19____, that I last saw the deceased alive on 8-30-57 , 19____, and that death occurred at 12P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. DATE SIGNED ACTUAL SIGNATURE TILL BERGEMANN, M.D. M.D. HYATTS. MD. PHYSICIAN'S NAME (Type) TILL BERGEMANN, M.D. HYATTS. MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 9/3/57		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Masoleum	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 3 1957	
24b. REGISTRAR'S SIGNATURE Gasch					

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RECEIVED

08756

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
f. STREET ADDRESS 1 Maple Lane Cherry Hill Tr. Ct.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maybelle Middle M Last Cary		4. DATE OF DEATH Month August Day 8 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Murray		14. MOTHER'S MAIDEN NAME Caroline Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Melvin Whaley		Address Del. 1220 New St. Wilmington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perforation small intestine. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 8/7/57 , 19 57 , to 8/8 , 19 57 , that I last saw the deceased alive on 8/8 , 19 57 , and that death occurred at 6:00 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE James R. Goodson M.D.		DATE SIGNED Aug. 8 1957	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-10-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive	22d. LOCATION (City, town, or county) _____ (State) _____ Delmar, Del.
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Gurnel Co - Delmar, Del.		24a. REC'D BY REGISTRAR DATE AUG 13 '57	
24b. REGISTRAR'S SIGNATURE W. L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAR. LAND STATE DEPARTMENT OF HEALTH - BUREAU ONE 18

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AUG 13 1957

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W. J. OLIVE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08765

08757

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5917 28th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Wilfred Last Chapman				4. DATE OF DEATH Month August Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-57		9. AGE (In years last birthday) yrs. 14	IF UNDER 1 YEAR Months 14	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Wesley Chapman				14. MOTHER'S MAIDEN NAME Virginia Mosley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, no, or unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Father; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 13-57		22b. DATE THEREOF Aug 13-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switzland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros 1661- good Hope Rd				24a. REC'D BY REGISTRAR Aug 14 '57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 14 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08766

08758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>				c. LENGTH OF STAY IN 1b <u>1 hr 55 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drentwood 34</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>4006 38th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chick</u>				4. DATE OF DEATH Month Day Year <u>August 2 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 2, 1957</u>	
9. AGE (In years, lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1 55</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Raymond Chick</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Dahlstedt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 2, 1957</u> , to <u>August 2, 1957</u> , that I last saw the deceased alive on <u>August 2, 1957</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin S. Miller</u> M.D.				ADDRESS (Street, city or town, state) <u>3824-34th Int. Palmer Aug 2 1957</u>			
PHYSICIAN'S NAME (Type) <u>Benjamin S. Miller</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial Aug 1957</u>		<u>Aug 1957</u>		<u>Prince Georges Cemetery Chesverly Md</u>		<u>Chesverly Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Ben</u> ADDRESS <u>1100 N. Adams</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

08468

REG. NO. 100

1. PLACE OF DEATH		2. NAME OF DECEASED	
3. SEX		4. AGE	
5. RACE		6. DATE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. PLACE OF BIRTH		12. PLACE OF DEATH	
13. OCCUPATION		14. EDUCATION	
15. MARITAL STATUS		16. RELIGION	
17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY	
19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS	
21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO	
23. PREVIOUS OTHER		24. PREVIOUS OTHER	
25. PREVIOUS OTHER		26. PREVIOUS OTHER	
27. PREVIOUS OTHER		28. PREVIOUS OTHER	
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CERTIFICATE OF DEATH

08767

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u> x0			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2208-Banning Place</u>				d. STREET ADDRESS <u>2208-Banning Place</u>			
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>M</u> Middle <u>CONVEY</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>10</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-13-179</u>	
9. AGE (In years, last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Albany, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Smyth</u>				14. MOTHER'S MAIDEN NAME <u>Alice Hogan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>334X</u>		17. INFORMANT <u>Alice M. Burns, Daughter</u> Address <u>as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>25 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1, 1946</u> to <u>Aug. 10, 1957</u> , that I last saw the deceased alive on <u>Aug. 10, 1957</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Ryan</u> M.D.				ADDRESS (Street, city or town, state) <u>401-W 7th St - Wash, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>William A. Ryan, MD</u>				DATE SIGNED <u>1</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u> ADDRESS <u>Mt. Rainier, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 13 '57</u>		24b. REGISTRAR'S SIGNATURE <u>DeLeon</u>	

CERTIFICATE OF DEATH

See Div. 14

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		65		JAN 15 1892		BALTIMORE		MD		USA			
MARRIED		WIFE		NAME		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
YES		JANE HARRIS		1895		BALTIMORE		MD		USA					
OCCUPATION		PROFESSION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
LABORER		LABORER		HIGH SCHOOL		METHODIST		WHITE		WHITE		5' 10"		175	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
HEART DISEASE		NATURAL		3 WEEKS		AUG 10 1957		BALTIMORE		MD		USA			
SIGNS AND SYMPTOMS		HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESSES		TREATMENT		DIAGNOSIS		PATHOLOGICAL FINDINGS		LABORATORY TESTS		POSTMORTEM EXAMINATION	
PAIN IN CHEST		PAIN IN CHEST		PAIN IN CHEST		PAIN IN CHEST		PAIN IN CHEST		PAIN IN CHEST		PAIN IN CHEST		PAIN IN CHEST	
SHORTNESS OF BREATH		SHORTNESS OF BREATH		SHORTNESS OF BREATH		SHORTNESS OF BREATH		SHORTNESS OF BREATH		SHORTNESS OF BREATH		SHORTNESS OF BREATH		SHORTNESS OF BREATH	
SWELLING OF FEET		SWELLING OF FEET		SWELLING OF FEET		SWELLING OF FEET		SWELLING OF FEET		SWELLING OF FEET		SWELLING OF FEET		SWELLING OF FEET	
LOSS OF APPETITE		LOSS OF APPETITE		LOSS OF APPETITE		LOSS OF APPETITE		LOSS OF APPETITE		LOSS OF APPETITE		LOSS OF APPETITE		LOSS OF APPETITE	
WEIGHT LOSS		WEIGHT LOSS		WEIGHT LOSS		WEIGHT LOSS		WEIGHT LOSS		WEIGHT LOSS		WEIGHT LOSS		WEIGHT LOSS	
FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY	
FATHER		FATHER		FATHER		FATHER		FATHER		FATHER		FATHER		FATHER	
MOTHER		MOTHER		MOTHER		MOTHER		MOTHER		MOTHER		MOTHER		MOTHER	
SIBLINGS		SIBLINGS		SIBLINGS		SIBLINGS		SIBLINGS		SIBLINGS		SIBLINGS		SIBLINGS	
OTHER RELATIVES		OTHER RELATIVES		OTHER RELATIVES		OTHER RELATIVES		OTHER RELATIVES		OTHER RELATIVES		OTHER RELATIVES		OTHER RELATIVES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE	
PLACE		PLACE		PLACE		PLACE		PLACE		PLACE		PLACE		PLACE	

BUREAU V. 2

AUG 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08759

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1 3903 Perry Street			
3. NAME OF DECEASED (Type or print) First Samuel Middle Roy Last Cornell				4. DATE OF DEATH Month Aug. Day 25, Year 19 57			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Street work		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee T. Cornell				14. MOTHER'S MAIDEN NAME Cora Hornsby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-204843		17. INFORMANT Marie M. Cornell; Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of brain DUE TO (c) Gunshot wound of head.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot by a pistol held in the hands of another man.					
20c. TIME OF INJURY Month, Day, Year 10.30 Hour 8-19- 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) (County) (State) Mt. Rainier, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				ADDRESS		24a. REC'D BY REGISTRAR August 25, 1957	
				24b. REGISTRAR'S SIGNATURE W. Gasch			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Kennedy	
Sex		Male	
Age		35	
Race		White	
Birth Date		1922-10-10	
Birth Place		New York	
Residence		New York	
Occupation		Student	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Examiner		John T. Kennedy	
Date		Aug 29 1957	

RECEIVED
BUREAU V. S.
 AUG 29 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08769

08813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>9685 Riggs Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>David</u> Last <u>Cruze</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>19 57</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1874</u>		9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Guard -Ret.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jack Cruze</u>				14. MOTHER'S MAIDEN NAME <u>Susan Houser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Ralph Cruze</u> Address <u>9685 Riggs Rd., Adelphi, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhaging</u> DUE TO (c) <u>Carcinoma of Stomach</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>10 days</u> <u>10 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-26-56</u> , 19 <u>56</u> , to <u>8-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-4</u> , 19 <u>57</u> , and that death occurred at <u>5:50p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Claire A. Christman</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Aug. 8, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Claire A. Christman, M.D.</u> <u>9703 Riggs Road, Adelphi, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington</u> <u>DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll NW</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 6 57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	

BUREAU V. S.

AUG 6 1957

RECEIVED

CERTIFICATE OF DEATH

08770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood				c. LENGTH OF STAY IN 1b 34			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3704-Taylor St.				d. STREET ADDRESS 3704-Taylor Street			
3. NAME OF DECEASED (Type or print) John R. Ousick				4. DATE OF DEATH Aug. 31 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/27/1882	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Emergency man Capitol Building, Bryanton, Md.				11. BIRTHPLACE (State or foreign country) U.S.A.			
13. FATHER'S NAME Austin Ousick				14. MOTHER'S MAIDEN NAME Georgie Farrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-10-7615			
17. INFORMANT John R. Ousick, Jr. above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Prostate DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 20, 1957, to Aug 31, 1957, that I last saw the deceased alive on Aug 28, 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE J. R. Raedy M.D.							
PHYSICIAN'S NAME (Type) R. Raedy MD				3701 Ely St Ch Ch Md Aug 31 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Valley's Funeral Home Mt Rainier Inc. Md				24a. REC'D BY REGISTRAR DATE SEP 4 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

BUREAU V. S.

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08771

08747

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>Alexandria</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> <u>VA. 83X-3</u>			
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacket Heart Home</u>				d. STREET ADDRESS <u>16 Belfield Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Virginia</u>		First Middle Last <u>Dainserfield</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1866</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Dainserfield</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Howell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Sacket Heart Home Records</u> Address <u>Box 1000 - Queen Charles Hwy - Huntersville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>may years</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 or more years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>31 July</u> , 19 <u>57</u> , to <u>5 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 Aug</u> , 19 <u>57</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5800 10th Place</u> DATE SIGNED <u>John W. Winkler Jr</u>							
ACTUAL SIGNATURE <u>John W. Winkler Jr</u> M.D. <u>5800 10th Place</u>				PHYSICIAN'S NAME (Type) <u>John W. Winkler Jr</u> <u>Chillum 11, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried Aug. 7-57</u>		<u>Aug. 7-57</u>		<u>Mt. Comfort Cem.</u>		<u>Chillum 11, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tom. Demme & Son Alexandria</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Aug 7 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>James L. Laver</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Marriages

Signature of Physician

Signature of Registrar

Signature of Informant

Signature of Coroner

Signature of Burial Officer

Signature of Undertaker

Signature of Mortician

Signature of Embalmer

Signature of Funeral Home

BUREAU V. 8

AUG 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08772
Reg. Dist. No.

08760

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs 1556.2 ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 12710 Laux Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lawrence Middle Lionel Last Dearstone				4. DATE OF DEATH Month August Day 24 Year 1957				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-29		
9. AGE (in years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Sand and gravel		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Halmér Dearstone				14. MOTHER'S MAIDEN NAME Flossie McAfee				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Halmér Dearstone; 12716 Gould Road, Silver Springs, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 925.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) External compression of chest and suffocation DUE TO (c) _____</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>								
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Buried under sand in a sand pit						
20c. TIME OF INJURY Month, Day, Year 1.30 8-24 1957 Hour XX p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sand pit		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED August 24, 1957				
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/27/57		22c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR AUG 27 '57		
				24b. REGISTRAR'S SIGNATURE W. E. Humphrey				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. Jones		Male		45		Aug 27 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Carpenter		High School		Hypertension		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

AUG 27 1957

RECEIVED

COMMONWEALTH OF MASSACHUSETTS

TO TO FUNER DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08773

08744

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5021 Ontario Road		d. STREET ADDRESS 5021 Ontario Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle JOSEPH Last DENNING		4. DATE OF DEATH Month August Day 13th , Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19th, 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk--Retired		10b. KIND OF BUSINESS OR INDUSTRY Drug Store	
11. BIRTHPLACE (State or foreign country) Amsterdam, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael J. Denning		14. MOTHER'S MAIDEN NAME Mary Ellen Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 106-10-2852A	
17. INFORMANT Inez D. Jones		Address 6108--43rd St. Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 or 2 minutes about 6 mos. ? years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 7, 1957 to AUG 13, 1957 , that I last saw the deceased alive on AUG 10, 1957 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6311 Baltimore Ave. Riverdale Md. DATE SIGNED 8/13/57 ACTUAL SIGNATURE David S. Clayman PHYSICIAN'S NAME (Type) DAVID S. CLAYMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/16/1957	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR AUG 20 57	
24b. REGISTRAR'S SIGNATURE W.W. Chambers			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JULY 10, 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
BIRTH DATE		BIRTH PLACE	
JULY 10, 1892		BALTIMORE, MD	
MARRIAGE DATE		MARRIAGE PLACE	
JULY 10, 1915		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PREVIOUS ILLNESS		MANNER OF DEATH	
NONE		N	
PLACE OF DEATH		CITY	
BALTIMORE, MD		STATE	
COUNTY		CITY	
BALTIMORE		BALTIMORE	
STREET		CITY	
1234 E. BALTIMORE		BALTIMORE	
APARTMENT		CITY	
101		BALTIMORE	
ZIP CODE		CITY	
21201		BALTIMORE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE		DATE	
JULY 10, 1957		JULY 10, 1957	
PLACE		PLACE	
BALTIMORE, MD		BALTIMORE, MD	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	
STREET		STREET	
1234 E. BALTIMORE		1234 E. BALTIMORE	
APARTMENT		APARTMENT	
101		101	
ZIP CODE		ZIP CODE	
21201		21201	

BUREAU V. 81

AUG 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

08761

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08774

Reg. Dist. No. 745

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5713 Sheridan Street</u>				d. STREET ADDRESS <u>5713 Sheridan Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Claude</u> Last <u>Dennis</u>				4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>19 57</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-1890</u>			
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Dennis</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Matthews</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>U.S. Navy</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Fernanda Dennis, 5221 56th Avenue.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>462.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rupture of esophageal varices</u> (c) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>August 8, 1957</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Busche sons Hyattsville, Md</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>AUG 12 1957</u>			
						24b. REGISTRAR'S SIGNATURE <u>James Levey</u>			

10-101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. B.

AUG 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08815

CERTIFICATE OF DEATH

08775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 25, D.C.		c. LENGTH OF STAY IN 1b One Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1101st USAF Hospital, Andrews AFB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 43X-3	
3. NAME OF DECEASED (Type or print) First Sarah Middle Alice Last Denton		4. DATE OF DEATH Month August Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 December 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Daniel Westhead		14. MOTHER'S MAIDEN NAME Ellen Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clinical Records, US Naval Hosp, California		Address Corona	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, transitional-cell of urinary bladder 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 August, 19 57, to 13 August, 19 57, that I last saw the deceased alive on 12 August, 19 57, and that death occurred at 4:00 a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles L. Picus		ADDRESS (Street, city or town, state) 1101st USAF HOSPITAL (HATS), Wash. 25, D.C.	
DATE SIGNED M.D.			
PHYSICIAN'S NAME (Type) CHARLES L. PICUS CAPT, USAF (MC)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 23, 57	
22c. NAME OF CEMETERY OR CREMATORY Booth Cemetery		22d. LOCATION (City, town, or county) (State) Liverpool, 20, England	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington D.C.		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 15 '57		24b. REGISTRAR'S SIGNATURE Ole Leach	

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		REMARKS	
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DEGREE		DIPLOMA		OTHER	
RELIGION		METHODIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		BAPTIST		OTHER		REMARKS	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		SYMPTOMS		SIGNS		REMARKS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		REMARKS		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		REMARKS	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		REMARKS		REMARKS	

RECEIVED
AUG 15 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08762

CERTIFICATE OF DEATH

08776

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> 33		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>4122-46th st.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>Domlas</u> Last <u>Domlas</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 13-1885</u>	
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Morikirk Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. IT</u>	
13. FATHER'S NAME <u>Flooman Reese</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Conway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Sadie Gilbert 4122 46th st.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mammary Ca</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 17</u> , 19 <u>56</u> , to <u>Aug 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 21</u> , 19 <u>57</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jeanne C Bateman</u>		M.D. <u>1816 "R" St. NW, Wash DC</u>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Jeanne C Bateman M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-28-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Morikirk Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Washington</u>				ADDRESS <u>467 N. of 7th</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 57</u>	
				24b. REGISTRAR'S SIGNATURE			

RECEIVED

AUG 28 1957

BUREAU V. 2

RECEIVED		AUG 28 1957		BUREAU V. 2	
MINNESOTA STATE DEPARTMENT OF HEALTH - BALTICORE 10					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED JAMES EARL RAY					
2. SEX Male					
3. AGE 35					
4. DATE OF DEATH August 28, 1957					
5. PLACE OF DEATH St. Louis, Missouri					
6. CAUSE OF DEATH Suicide by gunshot wound of the chest					
7. MANNER OF DEATH Suicide					
8. SIGNATURE OF DECEASED James Earl Ray					
9. SIGNATURE OF WITNESS James Earl Ray					
10. SIGNATURE OF DECEASED James Earl Ray					
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99. SIGNATURE OF WITNESS James Earl Ray					
100. SIGNATURE OF DECEASED James Earl Ray					

MINNESOTA STATE DEPARTMENT OF HEALTH - BALTICORE 10

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) DOA on arrival 1401st USAF Hosp, Andrews AFB				d. STREET ADDRESS Route #2, Box 27		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN		First Middle Last LOUISE DOW		4. DATE OF DEATH August		Month Day Year 21 1957	
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 June 1957	
9. AGE (In years last birthday) 27		10. IF UNDER 1 YEAR Months 2 Days 19		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not applicable		10b. KIND OF BUSINESS OR INDUSTRY Not applicable		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Lawrence Roger Dow				14. MOTHER'S MAIDEN NAME DeLoris J. Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Lawrence R. Dow Address Father Rt #2, Box 27, Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital abnormalities, probable heart. 756.2 DUE TO Minimal Pulmonary Congestion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cause of death to be certified by physician DUE TO Minimal lymphoid hyperplasia of the bowel (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 August 1957, to 21 August 1957, that I last saw the deceased alive on See reverse side 12, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 21 Aug 1957 ACTUAL SIGNATURE Marvin E. Hashin M.D. 1401st USAF Hosp, AAFB, Washington 25, D.C. PHYSICIAN'S NAME (Type) MARVIN E. HASHIN CAPT., USAF(MC) 1401st USAF Hosp Andrews AFB, Wash 25, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Vancouver, Washington	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 517-11th St. S.E.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

AUG 23 57

21 August 1957: Deceased arrived at 1401st USAF Hospital, Andrews Air Force Base, Washington 25, D.C., at approximately 7:30 AM 21 August 1957.

I certify that deceased was DOA and I confirmed same at approximately 0730 hours 21 August 1957.

Marvin E. Haskin
MARVIN E. HASKIN CAPT., US F(MC)

BUREAU V. S.

AUG 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

08763

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b. D.O.A.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Route 1, Box 32	
3. NAME OF DECEASED (Type or print) Robert Mathew Fletcher		4. DATE OF DEATH Month August Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-49
9. AGE (In years last birthday) 8 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 57 Min.	11. IF UNDER 24 HRS. Months 8 Days 19 Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Fletcher		14. MOTHER'S MAIDEN NAME Sarah Louise Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. William Edward Fletcher; same address	
17. INFORMANT William Edward Fletcher; same address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture dislocation of cervical vertebra 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 812X DUE TO (c) 812X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck by an automobile while crossing street.		INTERVAL BETWEEN ONSET AND DEATH 19	
19a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Struck by an automobile while crossing street.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by an automobile while crossing street.	
20c. TIME OF INJURY Month, Day, Year 5.05 Hour 5:05 p. m. 8-19-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Mitchellville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 19, 1957	
22a. BURIAL, CREMATION, or REMOVAL (Specify) 8-22-57		22b. DATE THEREOF 8-22-57	
22c. NAME OF CEMETERY OR CREMATORY Holly Family Cem.		22d. LOCATION (City, town, or county) (State) Woodmore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons ADDRESS 467 N. St. N.W. Wash. D. C.		24a. REC'D BY REGISTRAR AUG 22 '57	
24b. REGISTRAR'S SIGNATURE W. L. Smith			

AUG 22 1957

08764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN 1b <i>16 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Land over,</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Leland Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Andrew Foerster</i>				4. DATE OF DEATH Month <i>8</i> - Day <i>7</i> Year <i>1957</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-25-93</i>	9. AGE (In years last birthday) <i>63</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Henry Foerster</i>				14. MOTHER'S MAIDEN NAME <i>Magdalene Sellner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>3</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Patient -</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Dis</i> (c) <i>Sudden death</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cirrhosis of Liver</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 22, 1957</i> , to <i>Aug 7, 1957</i> , that I last saw the deceased alive on <i>Aug 7, 1957</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>L W Malin</i> M.D.				ADDRESS (Street, city or town, state) <i>Riverdale, Md</i> DATE SIGNED <i>8-8-57</i>			
PHYSICIAN'S NAME (Type) <i>L W Malin M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/10/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>East Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F Gasche Sons Hyattsville Md</i>				24a. REC'D BY REGISTRAR DATE <i>12/19/57</i> 24b. REGISTRAR'S SIGNATURE <i>James Berday</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1957 12 AUG

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT..

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Transient			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New Hampshire b. COUNTY Belknap c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Conia 66x-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 14 South Main e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Herbert Francis Ford			4. DATE OF DEATH Month August Day 10 Year 19 57		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 6, 1910		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker		10b. KIND OF BUSINESS OR INDUSTRY Scott & Williams		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Leslie Ford		14. MOTHER'S MAIDEN NAME Nellie Chesse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 001-05-0139		17. INFORMANT Janette L. Bernier, Woonsocket, Rhode Island	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound fracture of the skull, crushed chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that was in an head on collision			
20c. TIME OF INJURY Month, Day, Year 8:10 a.m. 8/10 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301 Hall Prince George's Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 12, 1957	
22a. BURIAL, CREMATION, REMOVAL, SPECIFIC Transportation 8/12/57		22b. DATE THEREOF 8/12/57		22c. NAME OF CEMETERY OR CREMATORY Laconia	
22d. LOCATION (City, town, or county) New Hampshire		22e. (State) New Hampshire		22f. (State) New Hampshire	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR Aug 15 57	
24b. REGISTRAR'S SIGNATURE W. J. ...		24c. REGISTRAR'S SIGNATURE W. J. ...			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 15 1957
BUREAU V. 2

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Cause of Death		Manner of Death	
Medical History		Postmortem Examination	
Signature of Medical Examiner		Signature of Coroner	
Date of Certificate		Place of Issuance	

FOR STATE
HEALTH DEPT.

08766

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Hampshire b. COUNTY Belknap		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laconia 66x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's			d. STREET ADDRESS 14 South Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lucille Matilda Ford			4. DATE OF DEATH Month Day Year August 12 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1915		9. AGE (In years last birthday) 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New Hampshire	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Harold Stickney			14. MOTHER'S MAIDEN NAME Selina Belware		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT 149 Burrington Street Janette Bernier, Woomsocket, Rhode Island	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of the skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that was in an head on collision			
20c. TIME OF INJURY Month, Day, Year 8:10 8/10 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301 Hall Prince George's Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 12, 1957	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 8/12/57		22b. DATE THEREOF 8/12/57		22c. NAME OF CEMETERY OR CREMATORY Laconia	
22d. LOCATION (City, town, or county) New Hampshire		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.			24a. REC'D BY REGISTRAR AUG 15 '57		24b. REGISTRAR'S SIGNATURE <i>Overhaugh</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUG 15 1957
BUREAU V. 2

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten and printed text.

NAME: George A. Prince
AGE: 1 year
SEX: Male
RACE: White
DATE OF DEATH: August 12, 1957
PLACE OF DEATH: Home
CAUSE OF DEATH: Sudden Infant Death Syndrome
MANNER OF DEATH: Natural

Signature: [Handwritten Signature]
Date: August 15, 1957

CERTIFICATE OF DEATH

Reg. Dist. No. 24

08767

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivindale</u>				c. LENGTH OF STAY IN 1b <u>8m.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Eugene Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>2005 Powhatan Road</u>							
3. NAME OF DECEASED (Type or print) <u>William Walter</u> First <u>E.</u> Middle <u>Fowler</u> Last				4. DATE OF DEATH <u>August 2</u> 19 <u>57</u> Month <u>2</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>15</u> Min.		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Chart-Denver N. Fowler</u> Address <u>2005 Powhatan Rd., W. Hyatts, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Obstruction</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of stomach</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>18 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>8-1</u> , 19 <u>57</u> , to <u>8-2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-1</u> , 19 <u>57</u> , and that death occurred at <u>1:45</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4404 Guggensbury Rd</u>				DATE SIGNED <u>8-2-57</u>			
ACTUAL SIGNATURE <u>R F Wilkinson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>R F WILKINSON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Riverdale, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>AUG 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Severy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 6 of 10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Baltimore, Md</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1935</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. DATE OF DEATH <i>Aug 5 1957</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF REGISTRAR <i>John Doe</i>		18. SIGNATURE OF CLERK <i>John Doe</i>	
19. SIGNATURE OF CHURCH CLERK <i>John Doe</i>		20. SIGNATURE OF BURIAL CLERK <i>John Doe</i>	
21. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		22. SIGNATURE OF CEMETERY <i>John Doe</i>	
23. SIGNATURE OF HEALTH DEPARTMENT <i>John Doe</i>		24. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
25. SIGNATURE OF STATE CLERK <i>John Doe</i>		26. SIGNATURE OF NATIONAL CLERK <i>John Doe</i>	
27. SIGNATURE OF INTERNATIONAL CLERK <i>John Doe</i>		28. SIGNATURE OF UNITED NATIONS CLERK <i>John Doe</i>	
29. SIGNATURE OF WORLD CLERK <i>John Doe</i>		30. SIGNATURE OF OTHER CLERK <i>John Doe</i>	

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08768

CERTIFICATE OF DEATH

08783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		d. STREET ADDRESS 2600 16 th Street SOUTH	
3. NAME OF DECEASED First Middle Last LYDIA AMERIA GORMAN		4. DATE OF DEATH Month Day Year Aug 24 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13-1873
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		9b. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN PETER TALKLEY		14. MOTHER'S MAIDEN NAME EMILY BOUTELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT ADDRESS HOSPITAL RECORDS LAUREL SANITARIUM			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Gangrene left foot 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months in 1954	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1956, to Aug 24, 1957, that I last saw the deceased alive on Aug 24, 1957, and that death occurred at 1:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Erika P. Kraemer		DATE SIGNED Aug 25-57	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		ADDRESS (Street, city or town, state) Laurel Sanitarium	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 29, 1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Pulaski Cem.		22d. LOCATION (City, town, or county) Pulaski New York	
23. FUNERAL DIRECTOR'S SIGNATURE Willard Canfield		24a. REC'D BY REGISTRAR EP 3 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Nellie Brashear	

BUREAU V. S.

SEP 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G219 8-19-57 et

08769

CERTIFICATE OF DEATH

08784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH. D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		d. STREET ADDRESS 2900 R.I. AVE. N.E.	
3. NAME OF DECEASED (Type or print) First CLARA Middle Last GRIFFITH		4. DATE OF DEATH Month AUG. Day 8 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-90
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning Plant	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Festus Brooks		14. MOTHER'S MAIDEN NAME Georgia Claytor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 01 0922	
17. INFORMANT Joseph Brooks		Address Woodford Virginia.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Cervix ectocervix 171x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia, secondary to hydromyphorix DUE TO (c) Anemia, " " malignancy			INTERVAL BETWEEN ONSET AND DEATH 10 yrs Mo. 8. YR.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August , 19 56 , to 8/8 , 19 57 , that I last saw the deceased alive on 8/8 , 19 57 , and that death occurred at 15:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold I Lear M.D.		ADDRESS (Street, city or town, state) Par Sheridan St Hyattsville, Md.	
DATE SIGNED 8/9/57			
PHYSICIAN'S NAME (Type) Dr. Arnold Lear			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/12/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR AUG 13 57		24b. REGISTRAR'S SIGNATURE Redeem	

CERTIFICATE OF DEATH

Form No. 100

NAME OF DECEASED JOHN J. JOHNSON		DATE OF BIRTH 1900	
SEX MALE		RACE WHITE	
DATE OF DEATH 1957		PLACE OF DEATH HOME	
CITY BALTIMORE		COUNTY JOHNS HOPKINS	
STATE MARYLAND		ZIP CODE 21205	
DECEASED'S ADDRESS 1234 E. BALTIMORE ST.		DECEASED'S OCCUPATION LABORER	
DECEASED'S MARITAL STATUS MARRIED		DECEASED'S RELIGION CATHOLIC	
DECEASED'S EDUCATION HIGH SCHOOL		DECEASED'S SERVICE ARMY	
DECEASED'S PRESENT ADDRESS 1234 E. BALTIMORE ST.		DECEASED'S PRESENT OCCUPATION LABORER	
DECEASED'S PRESENT RELIGION CATHOLIC		DECEASED'S PRESENT SERVICE ARMY	
DECEASED'S PRESENT EDUCATION HIGH SCHOOL		DECEASED'S PRESENT MARITAL STATUS MARRIED	
DECEASED'S PRESENT ADDRESS 1234 E. BALTIMORE ST.		DECEASED'S PRESENT CITY BALTIMORE	
DECEASED'S PRESENT STATE MARYLAND		DECEASED'S PRESENT ZIP CODE 21205	
DECEASED'S PRESENT COUNTY JOHNS HOPKINS		DECEASED'S PRESENT RACE WHITE	
DECEASED'S PRESENT SEX MALE		DECEASED'S PRESENT NAME JOHN J. JOHNSON	

BUREAU V. S.

AUG 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08770

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b St. Leonard Post Office	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 44X0.2	
3. NAME OF DECEASED (Type or print) Alfred Anderson Gross		4. DATE OF DEATH Month August Day 12, Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1905
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Everett Gross		14. MOTHER'S MAIDEN NAME Eliza Wall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Etheline Gross; same address	
17. INFORMANT Etheline Gross; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED August 12, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Aug. 15, 57		22b. DATE THEREOF Brook's	
22c. NAME OF CEMETERY OR CREMATORY Island Creek		22d. LOCATION (City, town, or county) (State) 71.4	
23. FUNERAL DIRECTOR'S SIGNATURE P. L. Sewell, Ch. Frederick		24a. REC'D BY REGISTRAR DATE 8-10-57	
24b. REGISTRAR'S SIGNATURE A. H. Ward		AUG 20 '57	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: **George**
 SEX: **Male**
 AGE: **31**
 DATE OF BIRTH: **1926**
 PLACE OF BIRTH: **U.S.A.**
 OCCUPATION: **General Hospital**
 DECEASED AT: **General Hospital**
 DATE OF DEATH: **1957**
 TIME OF DEATH: **10:00 A.M.**
 CAUSE OF DEATH: **Myocardial Infarction**
 MANNER OF DEATH: **Natural**

Signature of Doctor: _____

Signature of Medical Examiner: _____

BUREAU V. 1

AUG 20 1957

RECEIVED

08771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08786

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville 15	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General		d. STREET ADDRESS 2024 Rittenhouse	
3. NAME OF DECEASED (Type or print) Robert Hampton Hall		4. DATE OF DEATH August 11 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 22, 1916
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY A&P Stores	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Robert Hall		14. MOTHER'S MAIDEN NAME Lilly Wade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Clara H. Hall, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture and dislocation of the 3rd and 4th cervicle (c) vertebrae caused the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off road and turned over.	
20c. TIME OF INJURY Month, Day, Year 4:45 p.m. 8/11 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	20f. (City or town) (County) (State) Upper Marlboro P.G. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 11, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/14/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR Aug 13 '57	
24b. REGISTRAR'S SIGNATURE DeLoach			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of Prince George's
 City of Washington
 State of Maryland
 Date of Death August 13, 1957
 Time of Death 10:30 A.M.
 Name of Deceased James L. Boyd
 Age 35
 Sex Male
 Race White
 Occupation
 Cause of Death
 Manner of Death

Signature of Medical Examiner
 Signature of Coroner
 Signature of Registrar
 Signature of Clerk

BUREAU V. 3

AUG 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 08787									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			c. LENGTH OF STAY (In 1b) 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1, Box 105					d. STREET ADDRESS Randolph Cooking Yard				
3. NAME OF DECEASED (Type or print) First Middle Last Vincent Lee Hall					4. DATE OF DEATH Month Day Year Aug 26 19 57				
5. SEX male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 19 57		9. AGE (In years last birthday) yrs. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hiker			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Carol Hall					14. MOTHER'S MAIDEN NAME Delano Reeder				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs H. Hall, Brandywine, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 921.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of food particles (c) Cachexia and asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE James I Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) James I Boyd					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8/28/57		22c. NAME OF CEMETERY OR CREMATORY St. Thomas		22d. LOCATION (City, town, or county) (State) Aquasco Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.					24a. REC'D BY REGISTRAR AUG 29 57		24b. REGISTRAR'S SIGNATURE		

2076234 XV3

NEW YORK STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is filled out with handwritten information, including a signature and date.

RECEIVED
AUG 29 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Tab. No. 10

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF SHERIFF		SIGNATURE OF CONSTABLE	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF DEPARTMENT CLERK	

REAU Y. 3

AUG 19 1957

RECEIVED

08818

CERTIFICATE OF DEATH

08789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)	c. LENGTH OF STAY IN 1b 2 mos., & 14 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	d. STREET ADDRESS 312 60th St., N.E., #A
3. NAME OF DECEASED (Type or print) First William Middle - Last Harris		4. DATE OF DEATH Month 8 Day 17 Year 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engineer		10b. KIND OF BUSINESS OR INDUSTRY Arlington Towers	9. AGE (In years last birthday) 59 yrs.
11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Harris		14. MOTHER'S MAIDEN NAME Sarah Hourison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ALVEOLAR CELL CARCINOMA BOTH LUNGS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 5 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/3/57 , to 8/17/57 , that I last saw the deceased alive on 8/17/57 , and that death occurred at 9:57 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 8/17/57 ACTUAL SIGNATURE Glenn Dale, Md. PHYSICIAN'S NAME (Type) Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8/19/57	22c. NAME OF CEMETERY OR CREMATORY Woodlaen	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE T.P.		24a. REC'D BY REGISTRAR DATE AUG 21 57	24b. REGISTRAR'S SIGNATURE W. L. Leach

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 21 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 220 9-20-57 ams

CERTIFICATE OF DEATH

08819 08790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE—MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE				c. LENGTH OF STAY IN 1b 4 mos 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSP.				d. STREET ADDRESS 73 FENTON ST. N.E.			
3. NAME OF DECEASED (Type or print) WILLIE HARRIS				4. DATE OF DEATH 8 24 19 57			
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/56	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) No. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME WILLIAM HARRIS			
14. MOTHER'S MAIDEN NAME SARAH FREEMAN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT FATHER Address 73 FENTON ST. N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENCEPHALOPATHY OF UNKNOWN ORIGIN OIOX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculous meningitis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MILIARY TUBERCULOSIS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/19 19 57 to 8/24 19 57 that I last saw the deceased alive on 8/24/57 , 19 57 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE MOE WEISS				ADDRESS (Street, city or town, state) GLENN DALE HOSP.			
PHYSICIAN'S NAME (Type) MOE WEISS M.D.				DATE SIGNED 8/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/25/57				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Bacon				ADDRESS 1722 7th St. N.W. Wash. D.C.			
24a. REC'D BY REGISTRAR AUG 27 57				24b. REGISTRAR'S SIGNATURE Qu. Smith			

F. S. G.

BUREAU V. 5

AUG 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08791

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Michigan b. COUNTY Wayne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Detroit 59 x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 11875 Whithorn	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marion Branson Hiatt		4. DATE OF DEATH Month Day Year August 13 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1909
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory Indiana	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Hiatt		14. MOTHER'S MAIDEN NAME Pearl Carman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Andrew E. Breuhan Detroit, Mich		12310 Wyoming Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 13, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/1957	
22c. NAME OF CEMETERY OR CREMATORY Martin W. Lysong Co-1300-N. St. C.		22d. LOCATION (City, town, or county) (State) Detroit Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Lysong		24a. REC'D BY REGISTRAR DATE AUG 14 '57	
24b. REGISTRAR'S SIGNATURE A. Leach			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ORIGINAL

BUREAU V. 3.

AUG 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08774

Item 11 Film G220 9-5-57 et

CERTIFICATE OF DEATH

08792

Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivindale</u>				c. LENGTH OF STAY IN 1b <u>2 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>#4 District Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deland Memorial Hospital</u>				d. STREET ADDRESS <u>#4 Deland Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>-</u> Last <u>Hoag</u>				4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1865</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Conneaut, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Thomas Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Chart</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> <u>450.0</u> DUE TO <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>undetermined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1957</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>June 17, 1957</u> , to <u>August 27, 1957</u> , that I last saw the deceased alive on <u>August 26, 1957</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Rivindale, Md</u>				DATE SIGNED <u>Aug 27, 1957</u>			
ACTUAL SIGNATURE <u>L. W. Malin</u>				M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>L. W. Malin MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairmont</u>		22d. LOCATION (City, town, or county) (State) <u>Blue Rapids, Kansas.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Williams</u>				ADDRESS <u>Em. 300-451 NE</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 28-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Edna F. Collins</u>							

BUREAU V. 5

AUG 30 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

08775

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince George		MARYLAND		STATE Md.		COUNTY Prince George	
CITY (If outside corporate limits, write RURAL and give nearest town) Riverdale		LENGTH OF STAY (in this place) 1 wk		CITY (If outside corporate limits, write RURAL and give nearest town) Laurel			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eugene Leland Mem.				STREET ADDRESS 412 1/2 Talbot Ave.		(If rural give location)	
3. NAME OF DECEASED (Type or Print) Grover C. Hobbs				4. DATE OF DEATH August 6 1957			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 10-29-84	
9. AGE last birthday 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Overseer Laurel Race Track		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Lewis Hobbs				14. MOTHER'S MAIDEN NAME Margaret Doyle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS Mrs. James Hobbs, Laurel Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
180X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Generalized Carcinomatosis Carcinoma left Kidney			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH 6.8 wks 6.8 wks			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 57, 1957, to Aug 57, 1957 that I last saw the deceased alive on Aug 6, 1957, and that death occurred at 3:40 PM, from the causes and on the date stated above.							
SIGNATURE Robert P. Ung		M.D.		ADDRESS (Street, city, town, state) Laurel, Maryland		DATE SIGNED Aug 6, 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/9/57		NAME OF CEMETERY OR CREMATORY Emmanuel Cem.		LOCATION (City, town, or county) (State) Seagerville Md	
24. REC'D BY REGISTRAR DATE AUG 13 1957		REGISTRAR'S SIGNATURE James Lewis		25. FUNERAL DIRECTOR'S SIGNATURE DeWitt Davidson		ADDRESS Laurel Md	

CERTIFICATE OF DEATH

REG. DISTRICT NO.

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

DATE

DECEASED

3. SEX

4. AGE

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF BIRTH

8. PLACE OF DEATH

9. PLACE OF DEATH

10. PLACE OF DEATH

11. PLACE OF BIRTH

12. PLACE OF DEATH

13. PLACE OF DEATH

14. PLACE OF DEATH

15. PLACE OF BIRTH

16. PLACE OF DEATH

17. PLACE OF DEATH

18. PLACE OF DEATH

19. PLACE OF BIRTH

20. PLACE OF DEATH

21. PLACE OF DEATH

22. PLACE OF DEATH

23. PLACE OF BIRTH

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47. PLACE OF BIRTH

48. PLACE OF DEATH

49. PLACE OF DEATH

50. PLACE OF DEATH

NOTIFICATION

BUREAU V. 1

AUG 18 1957

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE OF DECEASED		SEX OF DECEASED	
RACE OF DECEASED		EDUCATION OF DECEASED	
OCCUPATION OF DECEASED		MANNER OF DEATH	
CAUSE OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. S.

AUG 13 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08820

CERTIFICATE OF DEATH

08795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
c. LENGTH OF STAY IN 1b 1 yr. 2 mos. & 21 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 401 Brandywine St., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodore Middle R. Last James				4. DATE OF DEATH Month 8 Day 6 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/07	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special police detective				10b. KIND OF BUSINESS OR INDUSTRY National Detective Agency		11. BIRTHPLACE (State or foreign country) Tenn.,	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Dunkin James				14. MOTHER'S MAIDEN NAME Beulah Sheckelford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 4/16/23-4/26		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c) 13 yrs.,						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic empyema, left; cor pulmonale						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour o. s. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/16 , 19 56 , to 8/6 , 19 57 , that I last saw the deceased alive on 8/6 , 19 57 , and that death occurred at 1:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 8/6/57							
ACTUAL SIGNATURE Moe Weiss		PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/9/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington Mt. Cem		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Gilbert C. Vincent				24a. REC'D BY REGISTRAR AUG 8 '57		24b. REGISTRAR'S SIGNATURE W. H. ...	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1912		BALTIMORE, MD.	
RESIDENT OF		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
1234 E. BALTIMORE ST.		AUG 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE	
CLERK		HIGH SCHOOL		YES		YES		YES		JAN 15 1935	
PREVIOUS ILLNESS		DATE OF ILLNESS		PLACE OF ILLNESS		CAUSE OF ILLNESS		MANNER OF ILLNESS		CERTIFICATE NO.	
NONE		JUL 1 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF EXAMINATION		MANNER OF EXAMINATION		CERTIFICATE NO.		12345	
AUG 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345		12345	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF SIGNATURE		MANNER OF SIGNATURE		CERTIFICATE NO.	
J. H. HARRIS		AUG 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF SIGNATURE		MANNER OF SIGNATURE		CERTIFICATE NO.	
J. H. HARRIS		AUG 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345	

BUREAU V. 2

AUG 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08821

CERTIFICATE OF DEATH

08797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkshire</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkshire</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7401 INSEY ST</u>		d. STREET ADDRESS <u>7401 Insey St</u>	
3. NAME OF DECEASED (Type or print) <u>BRIDGET</u> First Middle Last		4. DATE OF DEATH Month <u>AUG</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Patrick Murphy</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Garrett Johnson</u>		Address <u>7401 Insey St, Berkshire Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis.</u> 332 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/2</u> , 19 <u>57</u> , to <u>8/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>57</u> , and that death occurred at <u>7:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Lawrence Phillips</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glennview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Long Branch, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington, D.C.</u>		24. REC'D BY REGISTRAR <u>Aug 6 57</u>	
24b. REGISTRAR'S SIGNATURE <u>D. L. Smith</u>			

CERTIFICATE OF DEATH

FILE NO. 10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 1, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESSES <i>Mr. & Mrs. Doe</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF CLERK <i>John Doe</i>		14. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>		15. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>	

BUREAU V. S.

AUG 6 1957

RECEIVED

08778

Item 2 Film G220 10-1-57 at

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Pri. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 616 - 10th Street			
c. LENGTH OF STAY IN 1b 7 Days				d. STREET ADDRESS Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred Middle Kelly Last Kelly				4. DATE OF DEATH Month Aug Day 30 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-23-04	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 7 Hours 15 Min.		IF UNDER 24 HRS. Months 53 Days 7 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertension and cardiovascular renal disease (c) maligant neoplasia of the lungs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-24-1957 to 8-30-1957 that I last saw the deceased alive on 8-30-1957 , and that death occurred at 8:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert Roth M.D.				ADDRESS (Street, city or town, state) Riverdale Maryland			
PHYSICIAN'S NAME (Type) Albert Roth				DATE SIGNED 8/31/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-2-57		22c. NAME OF CEMETERY OR CRIMATORY Bacon's Chapel		22d. LOCATION (City, town, or county) (State) Laurel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Distrit Fun. Services ADDRESS				24a. REC'D BY REGISTRAR 498 DATE 8-31-57		24b. REGISTRAR'S SIGNATURE John D. Watson	

1700 Vermont Ave., N. W., Wash. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

SEP 3 1957

RECEIVED

08779

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vernal Middle Catherine Last Kuhn				4. DATE OF DEATH Month 8 Day 21 Year 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-03	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Chicago, Ill.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Anthony Gretzner				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Harry L. Kuhn, 3805--71st Ave., West Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 570.5 DUE TO Intestinal obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal obstruction DUE TO (c) Intestinal obstruction INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Arlington, Va.				20g. (County) Arlington			
21. I certify that I attended the deceased from 8-19-57 , 19____, to 8-21-57 , 19____, that I last saw the deceased alive on 8-21-57 , 19____, and that death occurred at 1:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas M. Hutchins				DATE SIGNED 8-22-57			
PHYSICIAN'S NAME (Type) Thomas M. Hutchins				M.D. 7315 Landover Rd Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.,		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE AUG 26 '57		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.

Name of Deceased James George		Sex Male		Age 21	
Date of Death 1-1-06		Place of Death Home		Cause of Death Heart Disease	
Occupation Student		Residence 1234 Main St.		City Baltimore	
County Harford		State Md.		Country U.S.A.	
Signature of Physician James George		Signature of Registrar James George		Signature of Coroner James George	
Date of Signature 1-1-06		Date of Signature 1-1-06		Date of Signature 1-1-06	

BUREAU V. 3

AUG 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08780

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08801

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4900 Lucerne Road			
3. NAME OF DECEASED (Type or print) First Robert Middle M. Last Lang				4. DATE OF DEATH Month August Day 19 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-07		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lang				14. MOTHER'S MAIDEN NAME Gertrude Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Florence A. Lang; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 19, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug. 21-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Seatons Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				ADDRESS 1661- Wood Hope Rd SE WASH. DC		24a. REC'D BY REGISTRAR DATE AUG 21 '57	
						24b. REGISTRAR'S SIGNATURE W. H. Beach	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		1910		New York		New York		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Physician's Name		Hospital Name		Date of Death	
Teacher		High School		Married		Hypertension		10/15/56		Dr. Smith		St. Mary's		10/20/56	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.
AUG 21 1957
RECEIVED

08781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle M. Last Lavigne				4. DATE OF DEATH Month 8 Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-57	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months 8 Days 8 Hours Min.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Robert Merlin J. LAVIGNE				14. MOTHER'S MAIDEN NAME RUTH SULLIVAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT FATHER Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/24 , 19 57 , to 8/1 , 19 57 that I last saw the deceased alive on 8/1 , 19 57 , and that death occurred at 12:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave. Cheverly Maryland DATE SIGNED John Kethoe							
ACTUAL SIGNATURE John Kethoe M.D. 3404 Cheverly Ave. Cheverly Maryland							
PHYSICIAN'S NAME (Type) JOHN KETHOE							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		AUG. 5, 1957		Arlington Hall		Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE L.W. Lattonell				ADDRESS 3603 14th ANN		24a. REC'D BY REGISTRAR DATE AUG 5 '57	
24b. REGISTRAR'S SIGNATURE W. H. H. H.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

AUG 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		4. DATE OF DEATH August 15 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apt. Building	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mabel Gross		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema, pulmonary edema 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute alcoholism DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 8-16-57	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/57	
22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines + Co - 901 Third St. S.W. WASH-D.C.		24a. REC'D BY REGISTRAR AUG 19 57	
24b. REGISTRAR'S SIGNATURE D. L. Branch			

FOR STATE
HEALTH DEPT.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
POSTAL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 3

AUG 19 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page, including "Wood-Ann" and "J. J. Smith".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08783 Item 7 Film 6219 8-12-57 et
CERTIFICATE OF DEATH

08803

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 E. RIVERDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		d. STREET ADDRESS 5308 KENILWORTH AVE.	
3. NAME OF DECEASED (Type or print) First BENNIE Middle LONG Last LONG		4. DATE OF DEATH Month AUGUST Day 7 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 4, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farmer (Ret.)	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John R Long		14. MOTHER'S MAIDEN NAME Ann E.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Virginia Matera - same as decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) Cerebral infarction of left hemisphere		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 50 , to 8-7 , 19 56 , that I last saw the deceased alive on 8-7 , 19 56 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Aaron Deitz		DATE SIGNED Aug 9 1957	
PHYSICIAN'S NAME (Type) DR. AARON DEITZ		ADDRESS Hagerstown, Md	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 8-10-57	
22c. NAME OF CEMETERY OR CREMATORY Methodist Church		22d. LOCATION (City, town, or county) (State) Wolfstown, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hansen		ADDRESS Wash. D. C.	
24a. RECEIVED BY REGISTRAR AUG 9 1957		24b. REGISTRAR'S SIGNATURE W. H. Smith	

5. 参考文献

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BUREAU V. S.

AUG 9 1957

RECEIVED

FOR STATE
HEALTH DEPT.

08784

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08804

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
f. STREET ADDRESS 1410 S. Street S. E.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES First HORACE Middle LONGLEY Last		4. DATE OF DEATH Aug. 3, 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Sept 1929
9. AGE (in years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		12. KIND OF BUSINESS OR INDUSTRY D.C. Fire Dept.	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY U. S. A.	
15. FATHER'S NAME Max E. Longley		16. MOTHER'S MAIDEN NAME Rose Mary Lopez	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		18. SOCIAL SECURITY NO. 1948 to 1952	
19. INFORMANT Mattie Buckley		Address Same as # 2 (Aunt)	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Trauma, multiple and severe (c), stating the underlying cause last. (c) Automobile accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with a bridge.	
20c. TIME OF INJURY Month, Day, Year 1:43 p.m. 1-3- 19 47		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Hattsville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED August 2nd, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington, D.C.		24. REC'D BY REGISTRAR - 24b. REGISTRAR'S SIGNATURE James Lewis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 6 1957

BUREAU V. S.

Operator of an automobile in collision with a bridge.

At the time of the accident

Driver, multiple and severe

fractures and shock

1957 to 1958 (date of death)

John T. McLaughlin

1957

U.S. Army Corp.

1957

U.S. A.

1957

1957

1957

1957

1957

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08805

08822

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3826 Rectory Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Nalle Magruder		4. DATE OF DEATH Month Day Year August 23, 1957.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Caleb Clarke Magruder		14. MOTHER'S MAIDEN NAME Bettie XXXX Rice Nalle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Oliver S. Hill-		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVA Disease DUE TO (c) Heart attack 4 yrs.		INTERVAL BETWEEN ONSET AND DEATH 15 min 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart attack 4 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to 23 Aug , 19 57 , that I last saw the deceased alive on 23 Aug , 19 57 , and that death occurred at 3:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Upper Marlboro, Maryland 8/23/57.			
ACTUAL SIGNATURE R. B. Sasscer		M.D. Upper Marlboro, Maryland 8/23/57.	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/57	
22c. NAME OF CEMETERY OR CREMATORY Magruder Family Plot		22d. LOCATION (City, town, or county) (State) Mitchellville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR AUG 27 '57		24b. REGISTRAR'S SIGNATURE W. J. ...	

author: name, phone, fax, e-mail

100

BUREAU V. S.

AUG 27 1957

RECEIVED

08785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b 16			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle R Last MAY				4. DATE OF DEATH Month AUGUST Day 3 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-98	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. 	IF UNDER 24 HRS. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME James Andrew Yeatman				14. MOTHER'S MAIDEN NAME Irene Victoria Bruce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Dorothy Martin Address Daughter above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous Sub-arachnoid Hemorrhage DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH immed 6 wks						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work 	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from June , 19 57 , to Aug 3 , 19 57 , that I last saw the deceased alive on Aug 3 , 19 57 , and that death occurred at 1:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3824-34th Mt Rainier Aug 3 1957 DATE SIGNED 							
ACTUAL SIGNATURE Benjamin S. Miller		M.D. 					
PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home, Mt. Rainier, Md.		ADDRESS 		24a. REC'D BY REGISTRAR 		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 10

NAME OF DECEASED: **THOMAS S. CHILDS** SEX: **MALE** AGE: **40** RACE: **WHITE** BIRTH: **1917** PLACE OF BIRTH: **NEW YORK**

Cause of Death

1. **HEART DISEASE**

2. **CHLORIDE SODIUM POISONING**

3. **CHLORIDE SODIUM POISONING**

4. **CHLORIDE SODIUM POISONING**

5. **CHLORIDE SODIUM POISONING**

6. **CHLORIDE SODIUM POISONING**

7. **CHLORIDE SODIUM POISONING**

8. **CHLORIDE SODIUM POISONING**

9. **CHLORIDE SODIUM POISONING**

10. **CHLORIDE SODIUM POISONING**

11. **CHLORIDE SODIUM POISONING**

12. **CHLORIDE SODIUM POISONING**

13. **CHLORIDE SODIUM POISONING**

14. **CHLORIDE SODIUM POISONING**

15. **CHLORIDE SODIUM POISONING**

16. **CHLORIDE SODIUM POISONING**

17. **CHLORIDE SODIUM POISONING**

18. **CHLORIDE SODIUM POISONING**

19. **CHLORIDE SODIUM POISONING**

20. **CHLORIDE SODIUM POISONING**

21. **CHLORIDE SODIUM POISONING**

22. **CHLORIDE SODIUM POISONING**

23. **CHLORIDE SODIUM POISONING**

24. **CHLORIDE SODIUM POISONING**

25. **CHLORIDE SODIUM POISONING**

26. **CHLORIDE SODIUM POISONING**

27. **CHLORIDE SODIUM POISONING**

28. **CHLORIDE SODIUM POISONING**

29. **CHLORIDE SODIUM POISONING**

30. **CHLORIDE SODIUM POISONING**

31. **CHLORIDE SODIUM POISONING**

32. **CHLORIDE SODIUM POISONING**

33. **CHLORIDE SODIUM POISONING**

34. **CHLORIDE SODIUM POISONING**

35. **CHLORIDE SODIUM POISONING**

36. **CHLORIDE SODIUM POISONING**

37. **CHLORIDE SODIUM POISONING**

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08807

08823

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendale Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendale Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1 Box 391 -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>McCallister</u> Last <u>SV</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocerman</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stan McCallister</u>		14. MOTHER'S MAIDEN NAME <u>Agnes McLean Glendale Md</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Florence McCallister</u>		Address <u>Glendale Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. ft.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 1956, to <u>Aug 7</u> , 1957, that I last saw the deceased alive on <u>Aug 6</u> , 1957, and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. James Kutz</u> M.D.		ADDRESS (Street, city or town, state) <u>RFD Bowie Md</u> DATE SIGNED <u>8/7/57</u>	
PHYSICIAN'S NAME (Type) <u>H. James Kutz</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 12 '57</u> 24b. REGISTRAR'S SIGNATURE <u>West</u>	

CERTIFICATE OF DEATH

Form 10-1-56

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 10 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>John J. Smith</i>		17. SIGNATURE OF WITNESS <i>John J. Smith</i>		18. SIGNATURE OF DECEASED <i>John J. Smith</i>	
19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF DECEASED <i>John J. Smith</i>		21. SIGNATURE OF DECEASED <i>John J. Smith</i>	
22. SIGNATURE OF DECEASED <i>John J. Smith</i>		23. SIGNATURE OF DECEASED <i>John J. Smith</i>		24. SIGNATURE OF DECEASED <i>John J. Smith</i>	
25. SIGNATURE OF DECEASED <i>John J. Smith</i>		26. SIGNATURE OF DECEASED <i>John J. Smith</i>		27. SIGNATURE OF DECEASED <i>John J. Smith</i>	
28. SIGNATURE OF DECEASED <i>John J. Smith</i>		29. SIGNATURE OF DECEASED <i>John J. Smith</i>		30. SIGNATURE OF DECEASED <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF DECEASED <i>John J. Smith</i>		33. SIGNATURE OF DECEASED <i>John J. Smith</i>	
34. SIGNATURE OF DECEASED <i>John J. Smith</i>		35. SIGNATURE OF DECEASED <i>John J. Smith</i>		36. SIGNATURE OF DECEASED <i>John J. Smith</i>	
37. SIGNATURE OF DECEASED <i>John J. Smith</i>		38. SIGNATURE OF DECEASED <i>John J. Smith</i>		39. SIGNATURE OF DECEASED <i>John J. Smith</i>	
40. SIGNATURE OF DECEASED <i>John J. Smith</i>		41. SIGNATURE OF DECEASED <i>John J. Smith</i>		42. SIGNATURE OF DECEASED <i>John J. Smith</i>	
43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF DECEASED <i>John J. Smith</i>		45. SIGNATURE OF DECEASED <i>John J. Smith</i>	
46. SIGNATURE OF DECEASED <i>John J. Smith</i>		47. SIGNATURE OF DECEASED <i>John J. Smith</i>		48. SIGNATURE OF DECEASED <i>John J. Smith</i>	
49. SIGNATURE OF DECEASED <i>John J. Smith</i>		50. SIGNATURE OF DECEASED <i>John J. Smith</i>		51. SIGNATURE OF DECEASED <i>John J. Smith</i>	
52. SIGNATURE OF DECEASED <i>John J. Smith</i>		53. SIGNATURE OF DECEASED <i>John J. Smith</i>		54. SIGNATURE OF DECEASED <i>John J. Smith</i>	
55. SIGNATURE OF DECEASED <i>John J. Smith</i>		56. SIGNATURE OF DECEASED <i>John J. Smith</i>		57. SIGNATURE OF DECEASED <i>John J. Smith</i>	
58. SIGNATURE OF DECEASED <i>John J. Smith</i>		59. SIGNATURE OF DECEASED <i>John J. Smith</i>		60. SIGNATURE OF DECEASED <i>John J. Smith</i>	
61. SIGNATURE OF DECEASED <i>John J. Smith</i>		62. SIGNATURE OF DECEASED <i>John J. Smith</i>		63. SIGNATURE OF DECEASED <i>John J. Smith</i>	
64. SIGNATURE OF DECEASED <i>John J. Smith</i>		65. SIGNATURE OF DECEASED <i>John J. Smith</i>		66. SIGNATURE OF DECEASED <i>John J. Smith</i>	
67. SIGNATURE OF DECEASED <i>John J. Smith</i>		68. SIGNATURE OF DECEASED <i>John J. Smith</i>		69. SIGNATURE OF DECEASED <i>John J. Smith</i>	
70. SIGNATURE OF DECEASED <i>John J. Smith</i>		71. SIGNATURE OF DECEASED <i>John J. Smith</i>		72. SIGNATURE OF DECEASED <i>John J. Smith</i>	
73. SIGNATURE OF DECEASED <i>John J. Smith</i>		74. SIGNATURE OF DECEASED <i>John J. Smith</i>		75. SIGNATURE OF DECEASED <i>John J. Smith</i>	
76. SIGNATURE OF DECEASED <i>John J. Smith</i>		77. SIGNATURE OF DECEASED <i>John J. Smith</i>		78. SIGNATURE OF DECEASED <i>John J. Smith</i>	
79. SIGNATURE OF DECEASED <i>John J. Smith</i>		80. SIGNATURE OF DECEASED <i>John J. Smith</i>		81. SIGNATURE OF DECEASED <i>John J. Smith</i>	
82. SIGNATURE OF DECEASED <i>John J. Smith</i>		83. SIGNATURE OF DECEASED <i>John J. Smith</i>		84. SIGNATURE OF DECEASED <i>John J. Smith</i>	
85. SIGNATURE OF DECEASED <i>John J. Smith</i>		86. SIGNATURE OF DECEASED <i>John J. Smith</i>		87. SIGNATURE OF DECEASED <i>John J. Smith</i>	
88. SIGNATURE OF DECEASED <i>John J. Smith</i>		89. SIGNATURE OF DECEASED <i>John J. Smith</i>		90. SIGNATURE OF DECEASED <i>John J. Smith</i>	
91. SIGNATURE OF DECEASED <i>John J. Smith</i>		92. SIGNATURE OF DECEASED <i>John J. Smith</i>		93. SIGNATURE OF DECEASED <i>John J. Smith</i>	
94. SIGNATURE OF DECEASED <i>John J. Smith</i>		95. SIGNATURE OF DECEASED <i>John J. Smith</i>		96. SIGNATURE OF DECEASED <i>John J. Smith</i>	
97. SIGNATURE OF DECEASED <i>John J. Smith</i>		98. SIGNATURE OF DECEASED <i>John J. Smith</i>		99. SIGNATURE OF DECEASED <i>John J. Smith</i>	
100. SIGNATURE OF DECEASED <i>John J. Smith</i>		101. SIGNATURE OF DECEASED <i>John J. Smith</i>		102. SIGNATURE OF DECEASED <i>John J. Smith</i>	

BUREAU V. 2

AUG 12 1957

RECEIVED

08786

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Capitol Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 5904 F Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Agnes		First		Middle		Last	
4. DATE OF DEATH Month August		Day 11		Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-3-66	
9. AGE (In years last birthday) 91		yrs.		IF UNDER 1 YEAR Months 11		IF UNDER 24 HRS. Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William McFarlane				14. MOTHER'S MAIDEN NAME Margaret Perry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Marian A. Barber--2026--34th St., SE, Wash, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 8/4 , 19 57 , to 8/11 , 19 57 , that I last saw the deceased alive on 8/11 , 19 57 , and that death occurred at 9:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William C. Weintraub				DATE SIGNED 8/12/57			
PHYSICIAN'S NAME (Type) Dr. William Weintraub							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 14-57 Addison Chapel Seat Pleasant 3rd		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661 Good Rd				ADDRESS Washington 20008 E.			
24a. REC'D BY REGISTRAR W. Beach				24b. REGISTRAR'S SIGNATURE W. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 14 1957

RECEIVED

08787

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 33 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood d. STREET ADDRESS 3908 Perry St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Minnie F. McLane				4. DATE OF DEATH Month Day Year August 5, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-16-77	
9. AGE (In years lost birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McKelvey				14. MOTHER'S MAIDEN NAME Susan Railing			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edward F. McLane Address 3908 Perry St. Brentwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obd. l. upper lobe. c 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pusulent pericarditis DUE TO (c) Intra cerebral hem. et. Sec. to Gen. Ar. sclerosis 33 days						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1957 , to Aug. 5, 1957 , that I last saw the deceased alive on Aug. 5, 1957 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Waldo B. Moyers M.D. 3503 Perry St. ME. Rainier Md P. 637							
ACTUAL SIGNATURE Waldo B. Moyers M.D. 3503 Perry St. ME. Rainier Md							
PHYSICIAN'S NAME (Type) Waldo B. Moyers 3503 Perry St. ME. Rainier Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town or county) (State) Bethesda Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chamber				ADDRESS 5801 Cleveland Rd. Bethesda Md		24. REC'D BY REGISTRAR Aug 12 '57	
				25. REGISTRAR'S SIGNATURE W W Chamber			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08810

Reg. Dist. No.

08788

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY Suffolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Heverly Md.		c. LENGTH OF STAY IN lb 6 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 25 La Rose Place	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last Corabell Mc Sherry</div>		4. DATE OF DEATH Month Day Year August 10 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harold Stickney		14. MOTHER'S MAIDEN NAME Selina ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Mc Sherry		Address Cape Vincent New York.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816x DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) Fracture of the skull, crushed chest DUE TO (c) fracture of the left femur</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> collision			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that was in an head on/	
20c. TIME OF INJURY Month, Day, Year 8:10 a.m. 8/10 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) road	
20f. (City or town) Hall		(County) (State) Pr. George's Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED August 11, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 8/12/57	
22c. NAME OF CEMETERY OR CREMATORY Boston		22d. LOCATION (City, town, or county) (State) Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE AUG 13 57		24b. REGISTRAR'S SIGNATURE W. Lee	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 13 1957

BUREAU V. S.

UNITED STATES DEPARTMENT OF HEALTH - BATHING 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 81			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tall Timbers 18x12		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) MARY First MAGDALENE Middle MOCKABEE Last				4. DATE OF DEATH Month August Day 5 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) St Mary's Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Owens				14. MOTHER'S MAIDEN NAME Myrtle Cooke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT 6808-23rd. Ave. Mrs. Mitchell Milkie W. Hyatts. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.0 Congestive DUE TO Fracture of left femur, Intro trochanter Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of left femur, Intro trochanter DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular renal disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall to ground from porch					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7/10/1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Shirley PS Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Aug 6, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-1957		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W.CHAMBERS CO.				ADDRESS 517-11th.St. S.E.		24a. REC'D BY REGISTRAR Aug 12 '57	
				24b. REGISTRAR'S SIGNATURE W. W. Chambers			

Washington D.C.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	

RECEIVED
AUG 12 1957
BUREAU V. S.

08790

CERTIFICATE OF DEATH

08812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>		d. STREET ADDRESS <u>207 Addison Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>VIRGINIA</u> Last <u>Naylor</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1888</u>
9. AGE (In years, last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>James Bedsworth</u>		14. MOTHER'S MAIDEN NAME <u>Ursula Sterling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Harry C. Naylor</u>		Address <u>207 Addison Rd. Seat Pleasant, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>451X</u> DUE TO <u>Lampnade</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>rupture aorta</u> DUE TO <u>arteriosclerosis</u> (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 10</u> , 19 <u>57</u> , to <u>Aug 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 31</u> , 19 <u>57</u> , and that death occurred at <u>8:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin M.D.</u>		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		DATE SIGNED <u>SEP 5 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chamber C.</u>		ADDRESS <u>Washington, D. C.</u>	
24a. RECD BY REGISTRAR <u>SEP 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Chamber C.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 5 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. DATE OF DEATH: [illegible]

7. PLACE OF DEATH: [illegible]

8. CAUSE OF DEATH: [illegible]

9. MANNER OF DEATH: [illegible]

10. SIGNATURE OF REGISTRAR: [illegible]

11. SIGNATURE OF DECEASED: [illegible]

12. SIGNATURE OF WITNESS: [illegible]

13. SIGNATURE OF PHYSICIAN: [illegible]

14. SIGNATURE OF CLERGYMAN: [illegible]

15. SIGNATURE OF FUNERAL HOME: [illegible]

16. SIGNATURE OF OTHER: [illegible]

17. SIGNATURE OF OTHER: [illegible]

18. SIGNATURE OF OTHER: [illegible]

19. SIGNATURE OF OTHER: [illegible]

20. SIGNATURE OF OTHER: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08813

Reg. Dist. No. *115*

08751

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier c. LENGTH OF STAY IN 1b 5 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4215 Rainier Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier d. STREET ADDRESS 4215 Rainier Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eleanor Matilda Newyahr 5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 4-22-04 9. AGE (in years last birthday) 53 yrs. 10. UNDER 1 YEAR 26 Months 11. UNDER 24 HRS. 19 57 Hours Min.		4. DATE OF DEATH August 26 19 57 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY New York 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Gelabort 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Mary Elizabeth Potter 17. INFORMANT F.R. Flick, Jr. Address 6604 Alleghaney Ave., Takoma, Pk.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 26, 1957 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8/29/57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National 22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR SEP 3 1957 24b. REGISTRAR'S SIGNATURE <i>Gasch</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

NAME: James Colquhoun SEX: Male AGE: 57 RACE: White

RESIDENCE: 1012 Reisterstown Avenue CITY: Baltimore STATE: Md.

DATE OF DEATH: September 2, 1957 TIME OF DEATH: 10:30 AM

PLACE OF DEATH: Home CAUSE OF DEATH: Coronary thrombosis

DATE OF BIRTH: March 10, 1900 PLACE OF BIRTH: New York

PREVAILING DISEASE: Cardiovascular disease

BUREAU V. 8

SEP 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08824

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08814

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia Park			c. LENGTH OF STAY IN 1b 1 year			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Columbia Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Boulevard				d. STREET ADDRESS 1 Maryland Boulevard			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roy Middle Lee Last Nicholson				4. DATE OF DEATH Month August Day 2 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1911		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Robert Nicholson				14. MOTHER'S MAIDEN NAME Leona Blanch Rickard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address William R. Nicholson, Riverdale, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of head (c) 976X DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted automatic pistol wound of head.							
20c. TIME OF INJURY Month, Day, Year Hour 8-2- p. m. 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fields		20f. (City or town) (County) (State) Columbia Park, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/3/57		22c. NAME OF CEMETERY OR CREMATORY Freddy's Funeral Home		22d. LOCATION (City, town, or county) (State) Gordonsville Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR Aug 6 57	
				24b. REGISTRAR'S SIGNATURE Redmond			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Robert Richardson	
Age		1 year	
Sex		Male	
Date of Death		Aug. 18, 1911	
Place of Death		Richmond, Virginia	
Cause of Death		Scurvy and shock	
Manner of Death		Natural	
Signature of Medical Examiner		George Elmer Richardson	
Signature of Coroner		William H. Richardson, Jr., Richmond, Virginia	

Self-inflicted traumatic plural wound of head.

BUREAU V. S.

AUG 6 1957

RECEIVED

Name of Deceased		John T. Jones, Jr.	
Age		33	
Sex		Male	
Date of Death		Aug. 18, 1911	
Place of Death		Richmond, Virginia	
Cause of Death		Scurvy and shock	
Manner of Death		Natural	
Signature of Medical Examiner		George Elmer Richardson	
Signature of Coroner		William H. Richardson, Jr., Richmond, Virginia	

08791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 HYATTSVILLE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 2219 SHERIDAN ST.	
3. NAME OF DECEASED (Type or print) First BERTHA Middle NOLTE Last NOLTE		4. DATE OF DEATH Month AUGUST Day 8 Year 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-80
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) COVINGTON, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS MEYER		14. MOTHER'S MAIDEN NAME LOUISE UNDERSTAHL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. ARTHUR J. NOLTE		Address SON.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY CARDIAC COLLAPSE 157x DUE TO JAUNDICE DUE TO EXTRA HEPATIC OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA - HEAD OF THE PANCREAS DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 1 MONTH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-10 , 19 57 , to 8-8 , 19 57 , that I last saw the deceased alive on 8-8 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Saul Schwartzbach M.D. PHYSICIAN'S NAME (Type) SAUL SCHWARTZBACH			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-13-57	22c. NAME OF CEMETERY OR CREMATORY ST. PETERS EVANGELICAL CEMETERY	22d. LOCATION (City, town, or county) (State) OKAWVILLE, ILLINOIS
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS, C.		24a. REC'D BY REGISTRAR 5801 CLEVELAND AVE. BALTIMORE	24b. REGISTRAR'S SIGNATURE Aug 14 '57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08792

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 219 9-3-57 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5012 26th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Benjamin Last Norris		4. DATE OF DEATH Month August Day 23 Year 19 57	
5. SEX M le	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-3-06
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat repairman		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William E. Norris		14. MOTHER'S MAIDEN NAME Agnes Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Etta Weidman; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of head (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted.	
20c. TIME OF INJURY Month, Day, Year Hour 7:20 p. m. 8-23-57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hillcrest Heights, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 24, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-1957	
22c. NAME OF CEMETERY OR CREMATORY Barth Lincoln		22d. LOCATION (City, town, or county) (State) Pr George Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly Wash, D.C.		24a. REC'D BY REGISTRAR Aug 26 '57	
24b. REGISTRAR'S SIGNATURE Overman			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - FARMINGTON 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPARTMENT

11, 1957

Kenneth

since deceased

Hilltop

1 hour

Gravity

3010 20th Avenue

since deceased General Hospital

Marine

Benjamin

John

20

12-1-55

white

white

W is

Washington, D.C.

Local residence

James Brown

William D. Morris

born before: was a

Lawrence and Brock

Quarantined wound of foot

Self-inflicted.

12-31-55

BUREAU V. S.

AUG 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08817

08825

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md			
f. STREET ADDRESS 4802 Prince George's St				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Guy Parker				4. DATE OF DEATH Month August Day 31 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 16, 1875	
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jacob O. Parker				14. MOTHER'S MAIDEN NAME Sarah Sanderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mrs Douglas Tschiffely				Address Washington D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary anemia - myocardial 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension - Prostatic Ca DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2m	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 5 Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8:30 , 19 55 , to 8:31 , 19 57 , that I last saw the deceased alive on 8/31 , 19 57 , and that death occurred at 8:31 M, from the causes and on the date stated above. ADDRESS (Street, city or town—state) _____ DATE SIGNED _____ ACTUAL SIGNATURE NB J. Steward M.D. Ransom PHYSICIAN'S NAME (Type) NB Steward Zakariya Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 2, 1957		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Beltsville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR SEP 3 57	
24b. REGISTRAR'S SIGNATURE P. J. ...							

BUREAU V. J.

SEP 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08748

CERTIFICATE OF DEATH

Reg. Dist. No.

08818

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HYATTSVILLE</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>			
c. LENGTH OF STAY IN 1b <i>6 yrs.</i>				1556.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hyattsville Convalescent & Rest Home</i>				d. STREET ADDRESS <i>9110 Glen Ridge Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Elizabeth C. PLITT</i>				4. DATE OF DEATH Month <i>AUGUST</i> Day <i>15</i> Year <i>57</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/14/73</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>			
11. BIRTHPLACE (State or foreign country) <i>md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Frederick Schwartz</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth List</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i></i>			
17. INFORMANT <i>Mrs. Louise Beauverd (Daughter)</i>				Address <i>Castle Manor Apts, Hyattsville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>congestive heart failure</i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>chronic pneumonia</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <i>9</i> p. m. 19 <i>57</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Oct 1956</i> , to <i>Aug 15 1957</i> , that I last saw the deceased alive on <i>Aug 15 1957</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Tice Bergemann</i> M.D. <i>4214 Jackson St</i>							
PHYSICIAN'S NAME (Type) <i>Tice Bergemann</i>				<i>Ally Shortz Mary Carr</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8/19/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>				ADDRESS <i>SILVER SPRING, MARYLAND</i>			
24a. REC'D BY REGISTRAR <i>Aug 17 1957</i>				24b. REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severe</i>			

CERTIFICATE OF DEATH

<p>1. Name of Deceased (Print Name and Last Name) [Illegible]</p>		<p>2. Sex [Illegible]</p>	
<p>3. Date of Birth [Illegible]</p>		<p>4. Date of Death [Illegible]</p>	
<p>5. Place of Birth [Illegible]</p>		<p>6. Place of Death [Illegible]</p>	
<p>7. Cause of Death (Print Name of Disease) [Illegible]</p>		<p>8. Immediate Cause of Death [Illegible]</p>	
<p>9. Duration of Illness (Print Name of Disease) [Illegible]</p>		<p>10. Date of Admission to Hospital [Illegible]</p>	
<p>11. Name of Physician (Print Name) [Illegible]</p>		<p>12. Name of Hospital (Print Name) [Illegible]</p>	
<p>13. Name of Coroner (Print Name) [Illegible]</p>		<p>14. Name of Registrar (Print Name) [Illegible]</p>	
<p>15. Name of Burial Place (Print Name) [Illegible]</p>		<p>16. Name of Cemetery (Print Name) [Illegible]</p>	
<p>17. Name of Funeral Home (Print Name) [Illegible]</p>		<p>18. Name of Undertaker (Print Name) [Illegible]</p>	
<p>19. Name of Embalmer (Print Name) [Illegible]</p>		<p>20. Name of Transporter (Print Name) [Illegible]</p>	
<p>21. Name of Burial Place (Print Name) [Illegible]</p>		<p>22. Name of Cemetery (Print Name) [Illegible]</p>	
<p>23. Name of Funeral Home (Print Name) [Illegible]</p>		<p>24. Name of Undertaker (Print Name) [Illegible]</p>	
<p>25. Name of Embalmer (Print Name) [Illegible]</p>		<p>26. Name of Transporter (Print Name) [Illegible]</p>	

BUREAU V. 3

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08819

08793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. HOSP</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E</u> Last <u>PROCTOR</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William H Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Margaret M. Savoy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>James E Proctor</u>		Address <u>Brandywine Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/7 1957</u> to <u>8/12 1957</u> , that I last saw the deceased alive on <u>8/12 1957</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert R. Riddle</u> M.D.		ADDRESS (Street, city or town, state) <u>Waldorf Md</u> DATE SIGNED <u>8/12/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Buried</u>		<u>Aug 14, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>St Peters</u>		<u>Waldorf Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>Aug 19 57</u>		<u>Orlando</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1957 19 AUG

RECEIVED

08794

CERTIFICATE OF DEATH

Reg. Dist. No.

08820

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Prexley Road			
3. NAME OF DECEASED (Type or print) First Laura Middle C Last Rice				4. DATE OF DEATH Month Aug Day 12 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 July 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Henry Campbell				14. MOTHER'S MAIDEN NAME Mary Laley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mary E Fitzgerald		Address Lanham Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Aug 3, 1957 to Aug 11, 1957 that I last saw the deceased alive on Aug 11, 1957 , and that death occurred at 5,20A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D Rosson MD		ADDRESS (Street, city or town, state) 5304 Annapolis Road DATE SIGNED Bladensburg, Maryland					
PHYSICIAN'S NAME (Type) Dr. William D Rosson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation	22b. DATE THEREOF 8/13/57	22c. NAME OF CEMETERY OR CREMATORY Amherst		22d. LOCATION (City, town, or county) Virginia (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR AUG 15 '57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4234

Reg. Dist. No.

Name of Deceased George Thomas		Sex Male		Age 2 days		Date of Birth March 1, 1957	
Place of Birth Baltimore, Maryland		Race Caucasian		Religion Roman Catholic		Marital Status Single	
Cause of Death Sudden Infant Death Syndrome		Contributing Cause None		Immediate Cause None		Underlying Cause None	

Date of Death March 2, 1957		Time of Death 10:00 AM		Place of Death Home		Physician's Name Dr. J. H. Smith	
Signature of Physician J. H. Smith		Signature of Registrar J. H. Smith		Signature of Coroner J. H. Smith		Signature of Medical Examiner J. H. Smith	
Signature of Burial Director J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Interment J. H. Smith	

Signature of Burial Director J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Interment J. H. Smith	
Signature of Burial Director J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Interment J. H. Smith	
Signature of Burial Director J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Interment J. H. Smith	

BUREAU V. S.

AUG 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08795

CERTIFICATE OF DEATH

Reg. Dist. No. 08821

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md			c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Cheverly Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5841 Dewey Street				d. STREET ADDRESS 5841 Dewey Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Burdette Walton Righter				4. DATE OF DEATH Month August Day 1 Year 19 57.				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1916		
9. AGE (In years lost birthday) 41 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Engineer				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Washington D. C.		
12. CITIZEN OF WHAT COUNTRY? U S A								
13. FATHER'S NAME Brudette S Righter				14. MOTHER'S MAIDEN NAME Viola Dunn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no				
17. INFORMANT Thelma S. Righter				Address Cheverly, Maryland.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myo-cardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) coronary thrombosis DUE TO (c) nothing							INTERVAL BETWEEN ONSET AND DEATH one hour one hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. 1. Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) Colmar Manor, Md.				20g. (County) Prince George's				
21. I certify that I attended the deceased from 9/14/56 , 19____, to 8/1/57 , 19____, that I last saw the deceased alive on 7/31/57 , 19____, and that death occurred at 12:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Road, Bladensburg, Maryland DATE SIGNED August 3rd, 1957								
ACTUAL SIGNATURE William D. Rosson				M.D. 5304 Annapolis Road, Bladensburg, Maryland				
PHYSICIAN'S NAME (Type) WILLIAM D. ROSSON, M.D.				August 3rd, 1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 5 '57		
24b. REGISTRAR'S SIGNATURE W. L. Leach								

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1912		New York City		New York City		Heart Disease		Jan 1, 1957		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Medical Advice		Last Medical Treatment		Last Medical Examination	
Teacher		Married		High School		Catholic		White		White		None		Jan 1, 1957		Jan 1, 1957		Jan 1, 1957		Jan 1, 1957		Jan 1, 1957	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner	
Jan 1, 1957		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.	

BUREAU V. S.

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08822

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

08796

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b DO A	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Carmody Hills, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 1 513 73 Street,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mettah Helen Rogers			4. DATE OF DEATH Month August Day 10, Year 19 57.		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 8, 1902		9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY A B C Lettering Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Charles Steele			14. MOTHER'S MAIDEN NAME Linda Carpenter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Harry L. Rogers Carmody Hills, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Reliance Virginia	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 11, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/14/57	22c. NAME OF CEMETERY OR CREMATORY Reliance Cemetery		22d. LOCATION (City, town, or county) (State) Reliance Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR AUG 15 '57	24b. REGISTRAR'S SIGNATURE W. Leach

STATE OF
HEALTH DEPT.

WYAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with various fields for medical examination and death certification, including sections for cause of death, manner of death, and examiner's signature.

RECEIVED
AUG 15 1957
BUREAU V. S.

John T. Williams, M.D.
John T. Williams, M.D.
WYAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 48 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 912 Barnabee St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marie Todd Russell				4. DATE OF DEATH Month Day Year August 13 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 09	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Pittsfield, Mass		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife IBM operator				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt			
13. FATHER'S NAME Kimbel				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none				16. SOCIAL SECURITY NO. yes		17. INFORMANT Walter D. Russell, Sr. Address 912 Barnaby St. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Cancer of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 , to 8/13/57 , 19____, that I last saw the deceased alive on 8/13/57 , 19____, and that death occurred at 9:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.C. Weintraub PHYSICIAN'S NAME (Type) W.C. Weintraub				ADDRESS (Street, city or town, state) 30 C. Ridge Rd. Greenbelt, Md DATE SIGNED 8/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington, D.C.				24a. REC'D BY REGISTRAR AUG 20 '57		24b. REGISTRAR'S SIGNATURE DeWich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

1957

1957

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	

BUREAU V. 1

AUG 20 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08826

CERTIFICATE OF DEATH

08824

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville	c. LENGTH OF STAY IN 1b 67 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville	
d. NAME OF HOSPITAL (If not in hospital, give street address) Defense Highway		d. STREET ADDRESS Defense Highway	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Elizabeth First Mary Middle Simpson Last		4. DATE OF DEATH Month August Day 16 Year 1957	
5. SEX Female	6. COLOR OF RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1884
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR: Months 73 Days XXX Hours XXX Min. XXX	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles John Kolbe	
14. MOTHER'S MAIDEN NAME Catherine Manbeck		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Miss Catherine M. Simpson-Mitchellville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Yes		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 1957 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 56 , to 8/16 , 19 57 , that I last saw the deceased alive on 8/13 , 19 57 , and that death occurred at 12:45 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		ADDRESS (Street, city or town, state) R. F. D. Bowie Md	
PHYSICIAN'S NAME (Type) H. James Kurtz		DATE SIGNED 8/16/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/19/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR AUG 22 1957	
24b. REGISTRAR'S SIGNATURE Agnes Jungling			

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Signature. Includes a large handwritten signature across the middle.

BUREAU V. S.

AUG 22 1957

RECEIVED

Handwritten notes and signatures at the bottom of the form, including "James K. Kato" and "8/13 1957".

08827

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. GS.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD</u>				c. LENGTH OF STAY IN 1b <u>10 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD, 34</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>3932 Allison</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian VERNICE Smith</u>				4. DATE OF DEATH Month Day Year <u>Aug - 8 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 3, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>MAGGIE THOMAS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Missouri Pollard N. BRENTWOOD Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8-1-57</u> <u>11-1952</u> <u>2-1956</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 5, 1957</u> to <u>Aug. 8, 1957</u> , that I last saw the deceased alive on <u>Aug. 5, 1957</u> , and that death occurred at <u>10:12 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. W. Spiller</u> M.D.				ADDRESS (Street, city or town, state) <u>4506 R.D. Ave, Brentwood</u> DATE SIGNED <u>8/9/57</u>			
PHYSICIAN'S NAME (Type) <u>W. W. SPILLER M.D.</u>				" " " " " " " "			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. RHINES + CO.</u>				ADDRESS <u>BY - ROBERT L. PLUMMER</u>		24a. REC'D BY REGISTRAR <u>Aug 12 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. W. Spiller</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES E. WEST		45		M		W		1912		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE	
MARRIED		1935		BALTIMORE		JANE WEST		1915		BALTIMORE	
OCCUPATION		DATE		PLACE		NAME		DATE		PLACE	
LABORER		1935		BALTIMORE		JANE WEST		1915		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
HEART DISEASE		1957		BALTIMORE		JANE WEST		1915		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
NATURAL		1957		BALTIMORE		JANE WEST		1915		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE		PLACE	
J. E. WEST		1957		BALTIMORE		JANE WEST		1915		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME		DATE		PLACE	
J. E. WEST		1957		BALTIMORE		JANE WEST		1915		BALTIMORE	

BUREAU V. 1

AUG 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08826

08828

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB, Washington, D.C.		c. LENGTH OF STAY IN 1b 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bldg. 1-100, Andrews AFB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB, Washington 25, D.C. x 2	
3. NAME OF DECEASED (Type or print) First Middle Last Louis Leroy Steiner		4. DATE OF DEATH Month Day Year August 30 1957	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 February 1925
9. AGE (In years last birthday) yrs. 32		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1st Lt. USAF		10b. KIND OF BUSINESS OR INDUSTRY U.S. A.F.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Worry L. Steiner		14. MOTHER'S MAIDEN NAME Freda Holden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes See Reverse		16. SOCIAL SECURITY NO. 231-30-0746	
17. INFORMANT maintained Address by individuals Personnel Records unit of assignment			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wound, missile, penetrating, right parietal 976x DUE TO region of head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unconfirmed, evidence indicates self inflicted missile wound.	
20c. TIME OF INJURY Month, Day, Year p.m. 1 Hour Aug. 30 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bldg 1-100, AAFB		20f. (City or town) (County) (State) Andrews AFB, Prince Georges, Md.	
21. I certify that I attended the deceased from 5:42 a.m. 19 to 30 August 1957, that I last saw the deceased alive on See Reverse*, 12, and that death occurred at * M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Reginald P. McManus M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1101st USAF Hospital 30 August 1957 Andrews Air Force Base	
PHYSICIAN'S NAME (Type) REGINALD P. MC MANUS CAPT, USAF (MC)		Washington 25, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-3-57	22c. NAME OF CEMETERY OR CREMATORY Tyrone, Pennsylvania	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 517-11th St. S.E.	
24a. REC'D BY REGISTRAR DATE SEP 5 '57		24b. REGISTRAR'S SIGNATURE Outreach	

T/Sgt Louis L. Steiner entered the Armed Forces 9 June 1942 and has remained in service until the present time.

CERTIFICATE

I, the undersigned, while in performance of duties as Medical Officer of the Day, for the 1401st USAF Hospital, do hereby certify that I was summoned to the deceased airman's quarters and found him dead upon my arrival thereat. It is my opinion that death occurred approximately 5 to 15 minutes prior to my arrival.

Reginald P. McManus
REGINALD P. MCMANUS
Captain, USAF (MC)
Attending Physician

BUREAU V. 3

SEP 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08827

08798

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial</u>		d. STREET ADDRESS <u>335 Main St</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM First PRICE Middle STEVENS</u> <u>Wm Stevens Jr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12 - 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B & O Railroad Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm F Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Alice Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Record Office</u>	
17. INFORMANT <u>Leland Memorial Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>200.1</u> <u>Lymphosarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 year</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Aug 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 18</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8/18/57</u>			
ACTUAL SIGNATURE <u>John R. Buell</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN R. BUELL</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 21 - 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel, Md</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Donaldson</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>Aug 22 1957</u>	24b. REGISTRAR'S SIGNATURE <u>James</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

61. BROWNE, J. L. 1979. THE EFFECT OF TEMPERATURE ON THE GROWTH OF THE BROWN TROUT, *Salmo trutta* L.

100-443887-100

AUG 22 1957

מחלקת המחקר והפיתוח

AUG 22 1957

RECEIVED

08799

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Chapel Oaks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5413 Nash Street	
3. NAME OF DECEASED (Type or print) Mary Lou Stewart			4. DATE OF DEATH August 31 19 57		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1892		9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Henry Clay Washington		
14. MOTHER'S MAIDEN NAME Laura Glasser Green			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mary Brown; same address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus; Arteriosclerotic heart disease.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 1, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery	
22d. LOCATION (City, town, or county) Suitland		22e. (State) Maryland		24a. REC'D BY REGISTRAR SEP 4 1957	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.		24b. REGISTRAR'S SIGNATURE W. H. Edwards		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 4 1957

RECEIVED

08800

CERTIFICATE OF DEATH

08829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Md</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>Carlyle</u> Last <u>Stilley</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 19-1883</u>
9. AGE (In years, lost birthday) <u>74</u> yrs. <u>6</u> Mophs <u>26</u> Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Owen Kelly Stilley</u>		14. MOTHER'S MAIDEN NAME <u>Emily Martha Warren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-30-0639</u>	
17. INFORMANT <u>Mrs Guy Perry</u>		Address <u>Item # 2 D</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion + edema</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lympho sarcoma</u> DUE TO (c) <u>Lympho sarcoma</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>200.1</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-24</u> , 19 <u>57</u> , to <u>8-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-15</u> , 19 <u>57</u> , and that death occurred at <u>6:05</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3503 Perry St.</u> DATE SIGNED <u>8-16-57</u>			
ACTUAL SIGNATURE <u>Waldo B. Moyers</u>		M.D. <u>3503 Perry St.</u>	
PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u>		<u>Mt. Rainier Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Thompson</u>		ADDRESS <u>Bethesda Md.</u>	
24a. REC'D BY REGISTRAR <u>Q. L. Branch</u>		24b. REGISTRAR'S SIGNATURE <u>Q. L. Branch</u>	
DATE <u>AUG 19 57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		12-1-22		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000 1/2 N. W. 10th St., Wash., D.C.		Author		High School		Married		6-6-68		Washington, D.C.	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
Gunshot wound of the chest		Suicide		I, the undersigned, being a duly qualified physician, and being duly sworn, depose and say that the foregoing is a true and correct statement of the facts and circumstances surrounding the death of the above named deceased.							
FINGERPRINTS		PHOTOGRAPH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	

BUREAU V. S.

AUG 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08829

CERTIFICATE OF DEATH

Reg. Dist. No.

0883143

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bowie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highbury Road</u>		d. STREET ADDRESS <u>1 Highbury Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Estelle Frances Sweeney</u>		4. DATE OF DEATH <u>August 16 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Reeland Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Hall</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT <u>Mrs. Grace Cowan, Bowie, Md</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> <u>Leukemia</u> DUE TO <u>Pylephlebitis, Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>years</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Arteriosclerosis Heart Disease Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Aug. 1954</u> to <u>Aug 16, 1957</u> , that I last saw the deceased alive on <u>8/15</u> 1957, and that death occurred at <u>9:45</u> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>H. James Kurtz</u> M.D. <u>RFD Bowie</u>	DATE SIGNED <u>8/16/57</u>
PHYSICIAN'S NAME (Type) <u>H. James Kurtz</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 19 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Reeland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Vanderson</u> ADDRESS <u>Reeland, Md</u>		24a. REC'D BY REGISTRAR <u>Aug 21 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Agnes Gough</u>

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08749

CERTIFICATE OF DEATH

08832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. LENGTH OF STAY IN 1b 33 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville Md.				d. STREET ADDRESS 4516 Burlington Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4516 Burlington Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bernard Middle S Last Thomas				4. DATE OF DEATH Month August Day 12 Year 19 57.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27, 1874		9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Insurance agent		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Chepas M Thomas			
14. MOTHER'S MAIDEN NAME ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs Lizzie M Thomas Address Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Prostate Gland 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. j. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Aug. 1 , 19 53 , to Aug. 12 , 19 57 , that I last saw the deceased alive on Aug. 12 , 19 57 , and that death occurred at 6:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 8/13/57							
ACTUAL SIGNATURE Charles C. Hagcage M.D. _____				PHYSICIAN'S NAME (Type) CHARLES C. HAGGAGE M.D. 3308 Perry St., Mt. Rainier, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Address Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE AUG 15 1957 24b. REGISTRAR'S SIGNATURE James Seery			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JULY 15, 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
BIRTHPLACE		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
MARRIAGE		CAUSE OF DEATH	
MARRIED		HEART DISEASE	
DATE OF MARRIAGE		MANNER OF DEATH	
JULY 10, 1930		NATURAL	
OCCUPATION		HOSPITAL	
LABORER		BALTIMORE HOSPITAL	
PREVIOUS ILLNESS		DATE OF ADMISSION	
NONE		JULY 10, 1957	
DATE OF DEATH		PLACE OF DEATH	
JULY 15, 1957		BALTIMORE HOSPITAL	
TIME OF DEATH		SIGNATURE OF PHYSICIAN	
10:00 AM		J. H. HARRIS	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
J. H. HARRIS		JULY 15, 1957	

BUREAU V. 3

AUG 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08801 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Thompson		4. DATE OF DEATH August 23rd 19 57	
5. SEX Female	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-23
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Nelson Smith		14. MOTHER'S MAIDEN NAME Louise A. Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO.	
17. INFORMANT LeRoy Paul Smith, Same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive heart disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 24, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-28-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Church		22d. LOCATION (City, town, or county) (State) Sanham Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		24a. REC'D BY REGISTRAR 28 57	
ADDRESS Saw 467 N. 7th		24b. REGISTRAR'S SIGNATURE Out. Lee	

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08802

08834

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4003-37th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Albert Middle E Last Toogood				4. DATE OF DEATH Month August Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/66	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Theatrical		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Toogood				14. MOTHER'S MAIDEN NAME Rebecca Wigman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Gertrude Lowes- Mt. Rainier, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Failure DUE TO (c) Generalized arteriosclerosis				1 day 1 month 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 1950 to Aug 1, 1957 that I last saw the deceased alive on Aug 1, 1957 , and that death occurred at 7:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Benjamin S. Miller				ADDRESS (Street, city or town, state) 3824-34th Mt Rainier Md DATE SIGNED 8-1-57			
PHYSICIAN'S NAME (Type) Benjamin S. Miller				3824 - 34th St. Mt. Rainier, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS Washington, D. C.		24a. REC'D BY REGISTRAR Aug 6 57	
				24b. REGISTRAR'S SIGNATURE Overman			

RECEIVED

AUG 6 1957

BUREAU V. S.

CERTIFICATE OF DEATH

WYOMING STATE DEPARTMENT OF HEALTH - BATHING 10

08833 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08835

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>2661 CHEVELEY AVE, MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH BEACH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2661 CHEVELEY AVE</u>		d. STREET ADDRESS <u>04X2.2</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>V</u> Last <u>TOZZOLO</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ST SILVESTER LAIACATA</u>		14. MOTHER'S MAIDEN NAME <u>CARMELA MONACO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>THOMAS TOZZOLO - N. BEACH MD.</u>	
17. INFORMANT Address <u>THOMAS TOZZOLO - N. BEACH MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>AND</u> (b) <u>Arteriosclerotic heart disease</u> (c) <u>ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/11</u> , 19 <u>57</u> , to <u>8/12</u> , 19 <u>57</u> . That I last saw the deceased alive on <u>8/11</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John K. Choe</u> M.D.		ADDRESS (Street, city or town, state) <u>3404 Chesley Ave Chesley, Md</u>	
PHYSICIAN'S NAME (Type) <u>John K. Choe</u>		DATE SIGNED <u>Aug 15 '57</u>	
22a. BURIAL, CREMATION, (Removal Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. W. Lees</u>		ADDRESS <u>WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Aug 15 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>M</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10-15-1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

RECEIVED
AUG 15 1957
BUREAU V. S.

08804

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clifford Earl Walker		4. DATE OF DEATH August 3, 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-96
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor foreman		10b. KIND OF BUSINESS OR INDUSTRY Gen. Serv. Admin.	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Abraham Lincoln Walker		14. MOTHER'S MAIDEN NAME Clara McCullough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Elizabeth Walker; Same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) stolting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> (b) <input type="checkbox"/> (c) <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 4, 1957	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/57	
22c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		ADDRESS	
24a. REC'D BY REGISTRAR AUG 7 '57		24b. REGISTRAR'S SIGNATURE Overbeach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 7 1957

BUREAU V. S.

Cardiologist, Royal Marine
Acute congestive heart failure

Henry Lincoln, M.D.; Gen. Sec.
Chas. McLaughlin

Gen. Sec. Admin. Labor Bureau

11-11-56 60

Station and Water

James George, General Hospital

1000 Tower Hill Road

Bellevue

D.M.

Heavily

James George

Bellevue

Pr. Geo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08830
CERTIFICATE OF DEATH

Reg. Dist. No.

08838

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine (rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Pearl Middle C. Last Washington				4. DATE OF DEATH Month August Day 23 Year 1957			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11 1894		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Andrew Dent				14. MOTHER'S MAIDEN NAME Maria Dent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Raymond Washington		Address Bryans Road, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Cardio-Vas-Neural Dis						INTERVAL BETWEEN ONSET AND DEATH About 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 19 57 , 19 40 , to 8-23 , 19 57 , that I last saw the deceased alive on 8-19 , 19 57 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George S. Weber				ADDRESS (Street, city or town, state) Waldorf MD			
PHYSICIAN'S NAME (Type) GEORGE S. WEBER MD				DATE SIGNED 8-23-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 27, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Piscataway Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 8/28/57	
				24b. REGISTRAR'S SIGNATURE John H. Pusey		24c. REGISTRAR'S SIGNATURE W. H. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08839

Reg. Dist. No.

08805

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Colmar Manor	
f. STREET ADDRESS 3415 40th Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Joseph Phillip Weber		4. DATE OF DEATH August 8, 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-21-1880	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		11b. KIND OF BUSINESS OR INDUSTRY Police	
11c. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Henry Weber		14. MOTHER'S MAIDEN NAME Eliza Jane Lynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jane Frances Weber; Same address.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. (c)	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 8, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 12, 1957	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson		24a. REC'D BY REGISTRAR Aug 12 57	
ADDRESS 1300 - N St N.W. WASHINGTON, D.C.		24b. REGISTRAR'S SIGNATURE Carl Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

AUG 12 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08840	
08831										CERTIFICATE OF DEATH	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>PR Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR Geo</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>					c. LENGTH OF STAY IN 1b <u>32 yrs 34</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4315-41st</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>Augustus</u> Last <u>WHITON</u>					4. DATE OF DEATH Month <u>AUG</u> Day <u>31</u> Year <u>1957</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 11, 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>ARCHITECT</u>		11. BIRTHPLACE (State or foreign country) <u>CONN</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Tudor Whiton</u>					14. MOTHER'S MAIDEN NAME <u>Eileen Bernard</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>TUDOR WHITON</u> Address <u>Hyattsville, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Failure</u> <u>450.0</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>W.L. Etienne</u> M.D. <u>4713-Berwyn Rd</u> PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u> <u>College PARK MD</u> 9/31/57											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			22d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u> (State) _____				
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Wash. D.C.</u> <u>-2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>SEP 3 57</u> DATE _____		24b. REGISTRAR'S SIGNATURE <u>W. L. Etienne</u>					

Medical Examiner Noted

9/3/57

W. E. F. F. F.

RECEIVED

SEP 3 1957

BUREAU V. S.

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BETHLEHEM, PA.

08806

CERTIFICATE OF DEATH

08841

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 15562			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RELAND MEMORIAL				d. STREET ADDRESS WHITE OAK, Boteler Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES S. WILSON				4. DATE OF DEATH Month Day Year AUGUST 12 1957			
5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/28/06	
9. AGE (In years lost birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Nelson Wilson				14. MOTHER'S MAIDEN NAME ELIZA JANE ANDERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 236-12-2962		17. INFORMANT Address Mrs. Norman J. Boteler, White Oak, Boteler Road Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema. 162x DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Bronchogenic carcinoma of lung. DUE TO 1 day. 1 day. (c) 1 1/2 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 11 , 1957, to Aug 12 , 1957, that I last saw the deceased alive on Aug 12 , 1957, and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED 8-12-57							
ACTUAL SIGNATURE L W Malin				PHYSICIAN'S NAME (Type) L W Malin M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/14/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				24a. REC'D BY REGISTRAR DATE Aug. 13, 1957		24b. REGISTRAR'S SIGNATURE Mrs. Joe. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08842

08807

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Mitchellville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS Route 1, Box 97		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Albert Robert Wood			4. DATE OF DEATH August 13, 1957		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> XX WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1943		9. AGE (In years last birthday) 14 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Oden Wood		
14. MOTHER'S MAIDEN NAME Irene Brooks			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Oden Wood; same address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) Drowning (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A poor swimmer, boy went into deep water and was drowned.			
20c. TIME OF INJURY Month, Day, Year 3.00 p.m. 8-13-57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) pool	
20f. (City or town) Bowie		20g. (County) Pr. Geo.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 13, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY Carroll Chapel Cemetery	
22d. LOCATION (City, town, or county) Collington, Maryland		22e. (State) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Fenwick		ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR DATE AUG 15 '57	
24b. REGISTRAR'S SIGNATURE W. J. Beach					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 15 1957

BUREAU V. S.

A post railway, not more than one year and was shown.

pool

6-12-57

John T. Hannon, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08843

08832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Largo Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle David Last Woods		4. DATE OF DEATH Month August Day 2 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1908
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Empl'd Machine Operator-Contracting		10b. KIND OF BUSINESS OR INDUSTRY Excavating	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Columbus Wiley Woods		14. MOTHER'S MAIDEN NAME Anna Laura Pickett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Lucy L. Woods		Address --Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchitis Pneumonia DUE TO (c) Secondary Anemia		INTERVAL BETWEEN ONSET AND DEATH 1 day 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour 9 a. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25, 1957 , to Aug 2, 1957 , that I last saw the deceased alive on Aug 2, 1957 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Sasser M.D.		ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 8-3-57	
PHYSICIAN'S NAME (Type) James G. Sasser, M.D.		Upper Marlboro, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/57	
22c. NAME OF CEMETERY OR CREMATORY Sleep Cemetery		22d. LOCATION (City, town, or county) (State) Sugar Grove, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR AUG 6 '57		24b. REGISTRAR'S SIGNATURE Arthur Smith	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922	
5. PLACE OF BIRTH Jackson, Tennessee		6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White	
9. DATE OF DEATH June 4, 1968		10. TIME OF DEATH 10:00 PM		11. PLACE OF DEATH FBI Headquarters, Baltimore, MD		12. CAUSE OF DEATH Suicide by gunshot	
13. MANNER OF DEATH Suicide		14. SIGNATURE OF PHYSICIAN [Signature]		15. SIGNATURE OF CORONER [Signature]		16. SIGNATURE OF DEATH REGISTRAR [Signature]	
17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF WITNESS [Signature]	
29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]		31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]	
33. SIGNATURE OF WITNESS [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF WITNESS [Signature]	
41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]	
45. SIGNATURE OF WITNESS [Signature]		46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF WITNESS [Signature]		52. SIGNATURE OF WITNESS [Signature]	
53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]	
57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
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65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]		67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]	
69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
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81. SIGNATURE OF WITNESS [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF WITNESS [Signature]	
89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]		91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]	
93. SIGNATURE OF WITNESS [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	

BUREAU V. S.

MAY 6 1967

RECEIVED